


Spring 1974

## Jefferson Alumni Bulletin – Volume XXIII, Number 3 Spring 1974

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# Jefferson

MEDICAL COLLEGE

ALUMNI  
BULLETIN  
Spring 1974





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## **sesqui-celebration**

Remember May 1, 1970? That was the evening at the Academy of Music when we celebrated the one hundredth anniversary of the establishment of the Alumni Association of Jefferson Medical College with a concert by the London Philharmonic. The two thousand alumni and guests who attended the celebration unanimously praised the event as one of Jefferson's finest.

We hope that Friday, November 15, 1974 will duplicate this success. To honor the founding of Jefferson Medical College one hundred and fifty years ago the Alumni Association of Jefferson will sponsor an all University event, again at the Academy of Music. The Royal Ballet of Sweden will be dancing in our honor that night and the performance will be followed by a champagne reception back on campus at Jefferson Alumni Hall. To complete the weekend program there will be a six o'clock reception on Saturday evening, November 16, at the Philadelphia Museum of Art. The Thomas Eakins galleries also will be open to us that Saturday with special lectures by the Museum staff on Eakins and his long and productive association with Jefferson.

Invitations to this final celebration of the Sesquicentennial year will not go into the mails until September. Hopefully, however, time will be blocked out on your fall calendar.

November 15 and 16, honoring one hundred and fifty years of medical education.



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The delightful rendering of the Academy of Music was done in conjunction with its 1857 opening. A Jefferson audience will fill Philadelphia's famed institution on November 15. (see opposite page)



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# The New Curriculum

by Thomas D. Duane, M.D., PhD.



*Dr. Duane*

***“It is easier to move a cemetery than to change a curriculum”***

**—Osler.**

When I was in the Navy I was assigned a tour of duty in Oak Ridge. I became friendly with one of the security officers and he drove me around one Sunday afternoon. We saw caravans miles inland from the perimeter being escorted with private security escorts. My guide informed me that the Manhattan Project could buy land, houses, shops and buildings but there was no way to gain possession of cemeteries. Consequently, every Sunday since its founding they had been escorting families to the grave sites—at no little expense to the taxpayers. This seemed incredible to me until I was assigned to Jefferson’s Curriculum Committee. Since then I have been convinced: Osler was right!

Shortly after I came to Jefferson (in 1962) we, the faculty, met in a retreat away from the College. In that sanctuary, among other things, we

decided that Jefferson Medical College needed a new curriculum and since Robert I. Wise, M.D., Ph.D., was Chairman of the Task Force which sold this idea, he was made the Chairman of the new Committee which, according to custom of those days, consisted exclusively of department chairmen.

This group went furtively to work and among other extraordinary accomplishments devised roughly twenty-five to thirty subcommittees assigned to organs, systems and topics. Each of these was composed of faculty members representing both basic and clinical sciences. They met frequently over a year or so and finally filed reports to the Master Committee. The reports covered the spectrum of knowledge and style and varied from incisive and perceptive evaluations of their particular area to rambling recommendations full of ambiguous pedagogical philosophy.

However, the former Curriculum Committee did a yeoman job and determined as well as possible what the faculty wanted to teach and on their own designed a formula assigning hours to the different disciplines. Upon receipt of this document, the then Dean, William A. Sodeman, convened a meeting at the Barclay Hotel where figuratively he “locked the doors” and told us to come up with a new curriculum or forever hold our peace. We got a new one. Of course no one was satisfied but under the circumstances it represented a major advance. There were many innovations. In the first place and for the first time at Jefferson, there was an allocation of time in the curriculum based upon a master plan rather than upon one’s seniority on the faculty. Secondly, electives were added to required subjects and thirdly, specified times for University-wide meetings and free periods for reading and digesting were brought into being.

Of course there were gripes—especially from those who were not on the Curriculum Committee, and at times, the Barclay meeting almost degenerated into a battleground.

I recall the late Jack Gibbon saying “Gentlemen, we have just ordained the demise of surgery at Jefferson.” (Even though general surgery was given ten weeks of clerkship and the surgical subspecialization eight weeks.) On the whole the former Committee performed well. The faculty only partially understood or cooperated with the new venture and many imperfections appeared only after the plan was in operation. There were many deficiencies. The chief weakness was the lack of cooperation by many departments who, confronted with less hours, merely talked faster and assigned more outside reading. Laboratory sessions were likewise compressed but on the whole were not reworked or redesigned. Electives, for the greater part, were uncoordinated and students were offered a bag of potpourri which lacked integration and frequently represented nothing much more than an instructor’s special interest whether it related well to what the students should know or not.

In spite of all these adverse criticisms—some justified—the Curriculum Committee made two major advances. One, it forced the faculty to think about the curriculum in a collective fashion, and secondly, it forced the faculty to communicate within its own membership. For this the students and alumni should be grateful. Through its efforts the work of those who followed was made considerably easier.

In 1968, Dean William F. Kellow installed or instituted a new philosophy at Jefferson. He forced the faculty to assume a much more democratic stature. In keeping with this movement, all committee composition was much more representative of the people involved. The

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*Dr. Duane has been Professor of Ophthalmology and Chairman of the Department at Jefferson since 1962. He recently was appointed Ophthalmologist-in-Chief at Wills Eye Hospital in Philadelphia (see page 27)*



**...it is more profitable  
to investigate what  
we have in hand, to  
make a realistic  
inventory of  
our strengths  
and deficiencies.**

new Curriculum Committee was composed of a few departmental chairmen but mainly the faculty at large was represented, and in addition students from the three upper years were assigned. Because the Department of Ophthalmology had given up more time proportionally than most others, and because I had griped the least (being busy with other tasks), and because many of the large departments had locked horns with others, and for completely intangible reasons, I was made the new Chairman. Dean Kellow met with us early in our career. He told us that just as in clinical medicine when the physician does not know precisely how to proceed under some circumstances it is wise for him to assume that the patient was a member of his own family and thus act accordingly. He advised us to do likewise; to create a curriculum we would want for one of our own children if he or she were to go to medical school (as mine did—elsewhere). The new Committee had two holdover members from the former Committee, Andrew J. Ramsay, Ph.D., of Anatomy and Joseph S. Connella, M.D., Associate Dean. More about them later. The challenge before us was formidable.

### **The Problem—"The Givens"**

To solve a "real time" problem one must commence with a set of conditions which are limiting factors when one is searching for a practical solution. We call these "the givens." If one begins with an ill-defined or incorrect set of givens, he may find an ideal solution which is not germane to the local problem in hand. Thus there was no sense at Jefferson in considering a one-to-one tutorial preceptorship for approximately nine hundred students. That simply wasn't in the cards.

Rather than dwell on what Jefferson can not do, it is more profitable to investigate what we have in hand, to make a realistic inventory of our strengths and deficiencies.

We are a large private medical school located in a changing central urban area. We have a moderate endowment but we must use tuition to help pay the freight. We have a cadre of full-time faculty mostly on the Jefferson campus and a large number of faculty members both at the Thomas Jefferson University Hospital and at fifteen affiliated hospitals. There exists an excellent basic science building, a superb library and a semi-modern hospital with approximately seven hundred beds located on the main campus with a new Clinical Teaching Facility in the planning stage. There is an outmoded out-patient building, the Curtis Clinic, and active plans to inhabit a new out-patient center, the former Edison Building at Ninth and Sansom Streets.

Jefferson depends upon State subsidy of its student citizens who are taught, and, conversely, the Commonwealth depends on Jefferson to help provide future physicians. Now Delaware has entered the act and we are under contract to teach her young men and women, also, in lieu of their building a medical school of their own. It is a fair assumption that all these students represent a fair cross section of the student market in the nation as a whole. Nevertheless it is a fact, regardless of the obvious recognition of a buyer's market for the Admissions Committee, that our potential student body is different from many other private medical

schools. In addition, Jefferson has long since recognized the need to offer many places to disadvantaged students, a fact which must be considered in any devised curriculum. These statements are in no way to be considered as complaints. They are merely statements of accepted facts.

Finally, the Medical College has since 1963 assumed a now well entrenched responsibility in conjunction with Pennsylvania State University to provide an opportunity for the gifted student to acquire a B.S. and M.D. degree five years following graduation from high school. This means approximately fifteen percent of the class must return to Penn State campus during the summers of their first two years in medical school. This sets limitations on the length of the school year and puts a formidable obstacle in the path of any proposal to utilize the summer vacations in the freshman and sophomore years.

So there you have it: a summary of the ingredients, namely the faculty, the student body and the facilities at Jefferson which similar to anywhere else influence the curriculum. No mention is made of the usual basic science-clinical rivalry; the clinical volunteer-full time faculty tug-of-war; the medical information explosion; the new type of students—beards, blue jeans, slightly cynical and arrogant, certainly critical and impatient—all these and many more factors are just part of today's scene at Jefferson and at just about all other

medical schools. Then there is the disappearance of the free standing internship in 1975, the changing requirements for residencies, the push for family medicine, the need for physicians in certain rural and urban areas, the uncertainties of the doctors' draft, the disappearance of federal monies for undergraduate medical education, all additional factors which serve to keep any curriculum committee off balance. So much for the givens.

### A Partial Solution

The answer to the above stated problem is termed "partial" for at least two reasons. Obviously, no curriculum is carved in marble; it must remain flexible even if it were excellent, since times change and so do the givens. In addition, though we have attempted to anticipate all contingencies, just as in any other new departure one can fully appreciate assets, weaknesses, additions, omissions and the like only after the scheme is in actual operation. For instance, the Curriculum Committee can schedule laboratory sessions or lecture hours but if the temper of the student finds these wanting, they will boycott them en masse and reassignment will be necessary, since the curriculum desperately needs to utilize every hour for learning or planned rest in the crowded four years.

The Curriculum Committee walks a tight rope. On the one hand, we are accused by the faculty of being wishy washy, acquiescing to every student whim and pampering insolent adolescent minority spokesmen of the student body. We, of course, deny these allegations. We try to inform each incoming class that we are well aware of the "pass-fail" system, and that we find it wanting. We think it is a cop out. We are sorry there is competition, but we recognize that it was not invented at Jefferson. If they do not care about their grades, others, especially residency review committees down the line, do.

Further, they have been in competition since preschool so a little more isn't going to break them. We recognize that though an 82.5 in pathology is not an absolute evaluation of a student's knowledge of the disease processes, it does tell us how he or she stacks up in the total scheme of things at Jefferson. Most importantly, it can tell us how to gear our teaching to eliminate a plethora of seventies and to stimulate those with nineties. In addition, we try to evaluate other components of competence, namely skills, judgment and attitudes. We are also forced to explain to trustees, faculty and students that we are well aware of three year curricula and though there is tremendous pressure on us to adopt this system, again we find it wanting. We do listen to student gripes. We do try to stagger examination periods. We do try to assist in the logistics of those students with clinical responsibilities at outlying hospitals. We do wish to encourage reasonable experimentation in the learning process. We do not, however, wish to supervise a travel bureau whence our students would go hither and yon to the far corners of the world particularly for special clinical exposure. We feel Jefferson may not be the world's best in every facet of medicine, but we are also not the worst and almost all aspects are pretty thoroughly covered somewhere within our "consortium-like" system of associated hospitals.

Finally, we wish to make the curriculum flexible, to allow it to improve with time, yet be concrete enough to satisfy students, their parents, our legislators, our accreditation groups, the National Boards, the licensing and specialty boards (also more later), our trustees and administration, our faculty and particularly future patients of our student bodies, that as a medical institution we are discharging our duty in a responsible fashion. The students think we are a conglomeration of stuffed shirts (with celluloid



collars) and the faculty think we are pigeons made of putty. We have learned to live with barbs and arrows as we plod along keeping our course in the main stream.

Our first order of business was to set our goals. After much discussion in Committee and with the professorial faculty, these finally gelled (see insert). Then a curriculum was devised to attain these goals.

The new (1972) curriculum (like Gaul) is divided into three parts or phases. Phase I is essentially the first two years of medical school (page 9). With rare exceptions (e.g., a Ph.D. in genetics or an M.S. in biochemistry), everyone is subjected to the same "locked-step" curriculum.

Traditionally, as any older Jefferson alumnus can testify, the beginning medical student began his medical career in the gizzard of a cadaver. We have changed this. There seems to be a much more natural transition from college to medical school by introducing biochemistry first. This is followed by a combination of genetics, embryology, general histology with some input from other departments into a course called "Cell and Tissue Biology." Next comes "Structure and Function," essentially gross anatomy and physiology. Thanks to careful, assiduous and responsible interplay between these departments as far as possible, these subjects are presented on a system basis. This is to say that when the anatomy of the G.I. tract or the cardiovascular system is under consideration so will its function be studied. Thus we have bent to the fad of integrating our teaching. But we have proceeded in a limited fashion which is quite different from going whole hog. In our opinion, those

## GOALS OF THE CURRICULUM

- A. To provide each student of Jefferson Medical College with an identical core curriculum which contains the sine qua non which should pertain to the M.D. degree.
- B. To provide each student of Jefferson Medical College with intermediate and advanced curriculum opportunities in order to prepare himself in some depth in one of the various areas of basic or clinical medicine.
- C. The curriculum as described herein will be such that the future physician will have a humanistic as well as a scientific approach toward the care and treatment of people with medical problems.
- D. Additional goals of the curriculum are:
  - 1. To have the students understand the tentative nature of scientific conclusions.
  - 2. To encourage the students to assume responsibility for their own education and to diminish their exclusive dependence on the teacher as a sole source of information.
  - 3. To encourage the students to think independently within the framework of social responsibility.
  - 4. To encourage the students to develop a logical approach to the analysis and management of clinical problems.

### In order to attain these goals it is proposed that:

- A. All core (basic and clinical) instruction be completed by the end of the third year in medical school. The third year itself will be devoted exclusively to clerkships.
  - 1. The first two years of instruction will encompass both a departmental and systems approach, the exact percentage of each to be based on the data provided by the Systems and Departmental reports with the view of achieving total integration by the end of the second year.
  - 2. The third year of medical school will consist of clinical clerkships including Community Health and Family Medicine; Internal Medicine; Obstetrics/Gynecology; Pediatrics; Psychiatry and Surgery.
- B. The last year of medical school will be devoted exclusively to intermediate and advanced curriculum based upon tracks provided by each of the basic and clinical departments.
- C. The Curriculum Committee will attempt to make reports of the Departments and Systems Committee as uniform as possible so that the Committee:
  - 1. Can determine what the faculty believes should be taught and learned.
  - 2. Can determine how much time should be allotted to the various areas.
  - 3. Can inspect the examinations given by faculty to determine how closely they are adhering to stated objectives.
  - 4. In addition, the reports will show the students what they are expected to learn and will provide valuable information to the faculty as to the content of the entire curriculum. Thereby the faculty responsible for teaching (departmental and systems) will know precisely what has preceded and what will follow their teaching.

maximal innovations at other schools have not been totally successful. Even if they were, it is our considered opinion that the climate is not ripe at Jefferson for such radical departures. Primarily, we have a large student body and only a partial dialogue between basic scientists and clinicians. Rewards for the faculty are parceled on a departmental basis and that is where orientation and loyalty of the faculty lie. The Curriculum Committee is not big enough to change this and even if we could we are a long way from being convinced that total system teaching is ideal or worth the candle.

Andrew J. Ramsay (now retired) was a guide in these matters. He had computed summaries of every medical school curriculum in the USA. We (through him) picked and chose what we liked and what was feasible at Jefferson. That he (and we) were on the right track is indicated by the published difficulties experienced in other schools.<sup>1</sup> That is not to say that we prohibit or discourage clinical input into the structure and function blocks. Indeed just the opposite. We encourage clinical input. But we leave it on a volunteer basis which is quite a different kettle of fish than trying to ram it down everyone's strictured craw. In ophthalmology for instance, we conduct a seminar for the freshmen on diseases of the orbit while they are studying the skull. We select a panel of young staff men and residents and show the students a series of patients with everything from retinoblastoma and rhabdomyosarcoma in youngsters to Graves disease and meningiomas in adults. There is an unplanned panel discussion (argument) on the diagnosis, treatment and prognosis with no quizzes, no grades on the students' part and they seem to enjoy the clinical exposure.

On an experimental basis we have tried to place the neurosciences into

a thoroughly integrated learning experience. Anatomy, physiology, neurology, neuropathology, otolaryngology and ophthalmology have joined forces and have attempted to teach the peripheral and central nervous system in one fell swoop.<sup>2</sup> This has had limited success for various reasons and will probably remain isolated from other systems of structure and function but will continue to serve as a warning to us not to push our luck too far in attempting totally integrated teaching. As it is, the students to a degree complain that though we teach systems, structure and function, back to back, not enough is done to entwine the two. Our answer is that all physicians must, on their own, learn to integrate. There is far too much information for us to put it all together, and each of us must compile and categorize on his own. This is the name of the game in clinical medicine and the sooner the student recognizes it the better he is prepared for his medical career.

The last course of the first year is "Mechanisms of Disease:" congenital, inflammatory, neoplastic, traumatic, etc. etc. It is mainly supervised by the Department of Pathology with some biochemical and clinical specialty input. The goal is to provide a background for an in-depth study of tissue and organ pathology in the fall of the sophomore year.

There are two courses which meet one afternoon a week for the entire year. One is called "Approach to the Patient." This is designed to teach histories and physicals more or less in parallel with structure and function. Obviously in the fall it is impossible to correlate with biochemistry. For this reason the course begins with emergency medicine, which starts with curbstone first aid and continues through emergency room responsibilities. Physical diagnosis demands some exposure to real live patients and this is not a simple logistical problem for the course director. However, through perseverance, persuasion and cajoling as well as

through long hours of hard work this, as is true with so many other headaches in the implementation of the curriculum, has been overcome. For the dedicated cooperation of many men and women on the faculty we and the students are deeply grateful. To avoid embarrassment I will not give names but the Curriculum Committee knows who these individuals are. It hasn't been easy for them and all of us including the alumni owe these tireless workers a heartfelt debt of thanks. They have made your Medical College a modern institution of which you can be proud.

The times demand, and so do we, that another continuous course be offered during the first two years. This is called "Medicine and Society." It is *not* a wastebasket of "what's left" e.g., the history of medicine, malpractice, medicine and religion, etc. It is an integrated, thought-out approach to the social and economic problems of today. It includes consideration of sociology, racial problems, urban and rural environmental medicine, behavioral medicine, drugs and crime, abortion, law, ethics and on and on.

This has been a tough course to organize and a tougher one to teach. It gives us little solace that it seems to be tough in all medical schools. One of the problems is that the scene keeps changing à la Toffler's *Future Shock* and our teachers are hard put to keep pace. Despite the grumblings from many sources we of the Curriculum Committee are adamant in our insistence that we continue with this tough nut because we are convinced it is necessary, and pragmatically we recognize that the

<sup>1</sup>Goldhaber, Samuel J.: Medical Education: Harvard Reverts to Tradition. Science 181:1027-1032, 1973.

<sup>2</sup>See Dean Ebert's comments center insert.



National Board is thinking in the same directions because they ask questions on these matters in Part I.

Finally June arrives and the winter of the freshmen's discontent is made summer by the opportunity of doing his thing any way he sees fit. The smart ones start reading a standard text in pathology.

When autumn returns Phase I B commences with a bang. Full time (with the exception of two afternoons for "Approach to the Patient" and "Medicine and Society") are devoted to clinical pathology. It's a tough ride but all signs including student approval, National Board results and clinical teacher appraisal later on indicate that they must be doing something right. Next come pharmacology and microbiology. There is little integration between these two but there has been agreement between them to stagger the course (as opposed to staggering the students) so that even the less capable student has the maximum opportunity to learn, as they say, "the drugs and bugs." The balance of the year is devoted to an "Introduction to Clinical Medicine." In essence this is the main didactic input from all clinical departments. It is a fast moving course but the students like it, and it enjoys a maximum correlation with National Board results which is an indication of some sort of relevancy.

There are several more aspects of Phase I which warrant description. Each course and course director (usually appointed by appropriate departmental chairmen) is asked to prepare an outline stating the course's objectives, concepts, skills and attitudes which are expected to be learned (and therefore taught) during the course exposure. The idea is to give the student and other faculty members some bird's eye

view of what is to be learned.

Incidentally or perhaps it should be said, quite on purpose, it forces the teachers to list their ideas in a uniform fashion for the benefit of the students, the rest of the faculty and most importantly of all, for themselves. This innovation has met with vigorous resistance, of which more later. Also requested are pre-examinations, again to help the course instructors and the students; these, again, are resisted. Finally, as stated, the Curriculum Committee has provided maximal clinical input mostly on an informal basis because we are maximally aware that too much basic science stifles the average student who came to school to learn about sick people. A few carrots of clinical exposure whets or refurbishes his or her appetite.

Finally, when Phase I is over the student is required to pass a comprehensive examination which at this time is Part I of the National Boards, for which time is set aside for reviewing. A few words about the National Boards are in order. Every time the curriculum is discussed by the faculty (and we have had a grand series of hot debates) there is always a colloquy devoted to the pros and cons of National Boards. The majority of the Curriculum Committee is pro National Board. That is not to say we fail to recognize some of its deficiencies. These are well known. The Boards are usually a bit behind the times. They represent the conservative, classical approach to medicine. They foster setting of standards by others than those who do teaching at Jefferson. Worst of all they test only recall, which rewards regurgitation, rather than an evaluation of skills, which rewards personal and practical integration and application.

In spite of these defects, the Curriculum Committee feels that a rather in-

bred, parochial medical school within the confines of a recently ordained life sciences university can well afford outside objective evaluation. All students must take and pass the Boards but these are not the sole criteria for passing or failing. Course grades (based upon examination and performance) in conjunction with National Boards serve as the final determination of who passes and who fails. We make no bones about wanting to do well in external examinations. And we do perform well. We have no sense of false pride nor of complacency about our record—*res ipsa loquitur*. We could do even better if we wanted to hand pick students with top grades via our Admissions Office. But we have other goals and other responsibilities. Nevertheless, Jefferson's record in these examinations is commendable overall, and for each course, and this fact bears recognition. We intend to continue in this vein.

Phase II begins in the fall of the junior year and covers a span of twelve months. There are some who would like to see it start earlier but fifteen percent of the class is in attendance at Pennsylvania State and the logistics of accommodating all becomes hopelessly snarled if we accept an earlier commencement date.

Actually Phase II is purely and simply a clinical clerkship in the big six. Medicine, surgery (and surgical specialties), pediatrics, obstetrics and gynecology, psychiatry: the traditional big five plus the new-comer, family medicine. This ought to be straightforward enough but it isn't. Again the Curriculum Committee insists on the format: objectives, concepts, skills and attitudes. Again we meet resistance. Further we insist on uniformity regardless of where the student spends his clerkship. This is

**PHASE I A****44 WEEKS**

BIOCHEMISTRY	CELL AND TISSUE BIOLOGY	STRUCTURE & FUNCTION	NEURO SCIENCES	MECHANISMS OF DISEASE
EMERGENCY MEDICINE			APPROACH TO THE PATIENT	
MEDICINE AND SOCIETY				

**PHASE I B****44 WEEKS**

PATHOLOGY	MICROBIOLOGY & PHARMACOLOGY	INTRODUCTION TO CLINICAL MEDICINE
APPROACH TO THE PATIENT		
MEDICINE AND SOCIETY		

**PHASE II****54 WEEKS**

CLINICAL CLERKSHIPS:  
MEDICINE  
SURGERY (AND SURGICAL SPECIALTIES)  
OBSTETRICS AND GYNECOLOGY  
PEDIATRICS  
PSYCHIATRY  
FAMILY MEDICINE

**PHASE III****36 WEEKS**

INTERMEDIATE AND ADVANCED CURRICULUM  
5 or 6 (MORE ?) TRACKS



to say if he takes ob/gyn at Lanke-nau and pediatrics at Thomas Jeffer-son University Hospital and surgery at Cooper he should expect to learn the same basic ideas as if he had re-versed the order. Naturally, all hospitals at all times of the year cannot provide identical clinical exposure. But assigned reading and seminar discussions can fill the bill. If there happens to be a run of pneumonia or fractures or what have you at any one of these hospitals, these can *supplement* the basic sine qua non but they must *not replace* it.

We have insisted that the appropri-ate departments determine what they want learned (as a minimum) and what they will hold the students re-sponsible for in the way of skills as well as concepts; that they tell us and the student; and that their examina-tions, grades and personal evaluations reflect these standards. There is no justification for flunking a student if he can't recognize a cardiac murmur or a large spleen or white cells in the

urine if no mention has been made that these skills were expected of him. We know it is hard to list these facets of clinical medicine. No one has ever pretended it was easy. But we are absolutely convinced that it is worth-while and we persist in our demands though we have made few friends in the process.

In his annual report to the faculty, 1972-1973, Dean Kellow summarized the problems and the approach as follows:

"The objectives of the clerkship phase need to be defined more sharply, and a program must be de-signed to meet them. Hopefully, this will be a period for a student to develop his skills as a diagnostician beginning with the establishment of rapport with the patient so that he obtains the patient's confidence and cooperation. Far too little emphasis is placed on the importance of the re-lationship between the doctor and his patient, and yet everyone recognizes that successful diagnosis and satisfac-

tory management depend on this relationship. The student's ability to shift his talent from didactic learning to the acquisition of skill in physical diagnosis and in the analysis of laboratory results is a whole new test of his capacity for medicine, and as students are evaluated in this new area, it is alarming how often serious deficiencies are discovered and how ill-prepared we are as a faculty to assist them in overcoming these handicaps. The planning for the clerk-ship phase requires profound thought, therefore, on methods to evaluate a student's progress as a diagnostician and also on new techniques for de-veloping the talents which are re-quired of students for medical practice."

Phase II covers twelve calendar months and includes a four week vacation.

Phase III begins in September of the senior or fourth year of medical school. It is called "Intermediate and Advanced Learning" and is still in



*Dr. Duane and Curriculum Committee members (from left) Dr. Joseph S. Gonnella, Dr. Edward H. McGehee, Dr. Marion J. Siegman and Dr. Joseph A. Zeccardi.*

utero. It is our biggest challenge because herein we plan to justify why we have foregone earlier alternatives such as a three year curriculum or a bag full of electives or a slower pace in the first three years. It is here that we wish to highlight the overwhelming importance of the biological basis of medicine to the advanced clinical practice—i.e., to the treatment of patients. And while we do this some way must be found to hammer home the attitudes of humanistic approaches to individual patient care, in other words, to the art of medicine.

A simple way to proceed would be to devise a way to divide the class among fifteen clinical departments. This will not be done. It is not that we decry esoteric medical specialization, indeed just the opposite holds true if one examines our residency training commitment as evidenced in terms of dollars, numbers of trainees or hours spent at Jefferson. Let it be said here to all concerned that more and more subspecialization is not only

a justifiable direction for a university medical center, it is an absolute necessity. Take ophthalmology for instance. We train young men and women resident physicians to do a history and physical of the visual system, something few have learned in medical school. In essence, these and a few more general skills especially along therapeutic (including surgical) lines is all we teach in the three years required by the American Board of Ophthalmology. But some of our graduates want to become retinal experts, or pediatric ophthalmologists, or corneal surgeons or plastic surgeons, etc., etc. It is easy to pooh pooh all this subspecialization but when the critic needs a corneal transplant, he wants the superspecialist who's batting average is significantly better than the average Board certified practitioner. Hence it is our duty to promote subspecialization (fleas upon fleas) in our center.

But this hardly serves the senior medical student who doesn't know

**...some way must  
be found to hammer  
home the attitudes  
of humanistic  
approaches to  
individual patient care,  
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to the art of medicine.**



*Dr. Richard G. Berry (right) makes point at the meeting with Dr. Frank D. Gray (left) and Dr. Wolfgang Vogel attentive listeners.*



**...there now appears  
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in the coming years  
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primary care.**

a plus lens from the canal of Schlemm. So our job is to coordinate our super-specialists with our embryo residents to the benefit of all. This is where the track system comes into the spotlight.

Though it has not been settled, let us for sake of departure state that there will be five or six tracks. For instance: surgery and surgical specialties, internal medicine, growth and development (pediatrics and ob/gyn), neurosciences and family medicine. Each student will be assigned to one track. For nine months, he will absorb all he can within that scope. The Curriculum Committee insists that approximately one third of the course be devoted to advanced basic science concepts as these apply to the track. Such concepts will be learned or relearned through various means: assigned reading, seminars, library research, student conferences—any way besides the conventional didactic lecture. Another one third of the year will be devoted to in depth amplification of what was learned in the clerkship. The last third will be concerned with an advanced approach to clinical problems within a given track's limitations.

It is our expectation that a majority of the students will spend this year in family medicine track. Perhaps the best way to explain why this philosophy has been adopted is to again quote Dean Kellow's report:

"The development of the new curriculum at Jefferson was preceded by a lengthy deliberation about future medical care, and there now appears to be a consensus, albeit with many modifying viewpoints, that the greatest change in medical practice in the coming years will be at the level of primary medical care. Many feel that the primary care physician of the 1980s will be an individual who is trained basically in internal medicine and pediatrics and is capable of rendering comprehensive care including the management of emergency situations, the less severe mental health problems, office gynecology and rehabilitation medicine.

It appears that this primary doctor will be called a family physician and that the family unit will be emphasized as the focus of medical care. This physician will expend much of his effort in an ambulatory setting where his talents will be extended by medical assistants who will relieve him of many of the things a doctor does today. Thus he will function more as a decision maker in the diagnostic and therapeutic areas and as an administrator of the medical team.

"Much agreement exists about the future of primary medical care and the way family physicians will function a decade or more from now. Yet our faculty has had to resolve other questions. Can a medical school like Jefferson, with its large classes and its comparatively small faculty, undertake an additional educational program to prepare some of our students to practice this new approach to primary medicine? This faculty is pleased with the progress which has been made in the last several decades in the education of students and residents for the more limited specialty areas. The quality medical care in the future will depend on continuing this progress as well as upon new emphasis in family medicine. We have had to consider, therefore, whether we can maintain all that has been gained in the development of programs for the more traditional specialties while we undertake much more in the primary care field; an endeavor which will require new affiliations, new patient care settings, relationships to rural and inner-city areas, and an additional faculty and allied health staff with an orientation to this new approach to primary care. The answers to these questions seem to be clearly positive, but reaching them has required considerable restructuring of the curriculum and also of the academic administration of the College.

"A new Department of Family Medicine has resulted from this restructuring, and this department is at work on the heavy tasks of bringing

together a faculty whose members agree with these same primary care objectives. The specific aspects of the educational program must be planned so that graduates in family medicine are prepared for the type of primary care in medical practice which is envisioned a decade from now. New resources at Jefferson, in the community, and even in more remote areas must be developed so that this program can be implemented in a manner which will provide these students with opportunities to learn about medical care in a variety of environments.

"Jefferson has been fortunate in obtaining the interest of the Robert Wood Johnson Foundation in this large undertaking. A grant has been made to enable us to assemble a planning staff to work with the faculty and officers in completing these plans and establishing resources and facilities for these new programs."

There are, of course, numerous criticisms leveled at our finished product even before it has seen the light of day. The student says: Give us our diploma at the end of the clerkship and let us plan our own residency career. I hope by now the reader will on his own anticipate our answer to that one. Some students also say: Why make us choose so early? What if we change our mind, a year has been wasted. We make them choose because they can't learn the whole body of knowledge. If one changes his mind later on, he does so on a much more informed basis. A year has hardly been "wasted." There are many concepts that apply to all disciplines. If one learns about the pituitary under the aegis of the Department of Ob/Gyn and later chooses to become a neurosurgeon or a pediatrician or an internist he has patently not "wasted" his time.

The faculty say: Things were just going smoothly and now a group of would-be educators (the Curriculum Committee) is rocking the boat. Again, we hide under the Dean's skirts. In the report he said: "When we come to plan the alternative track

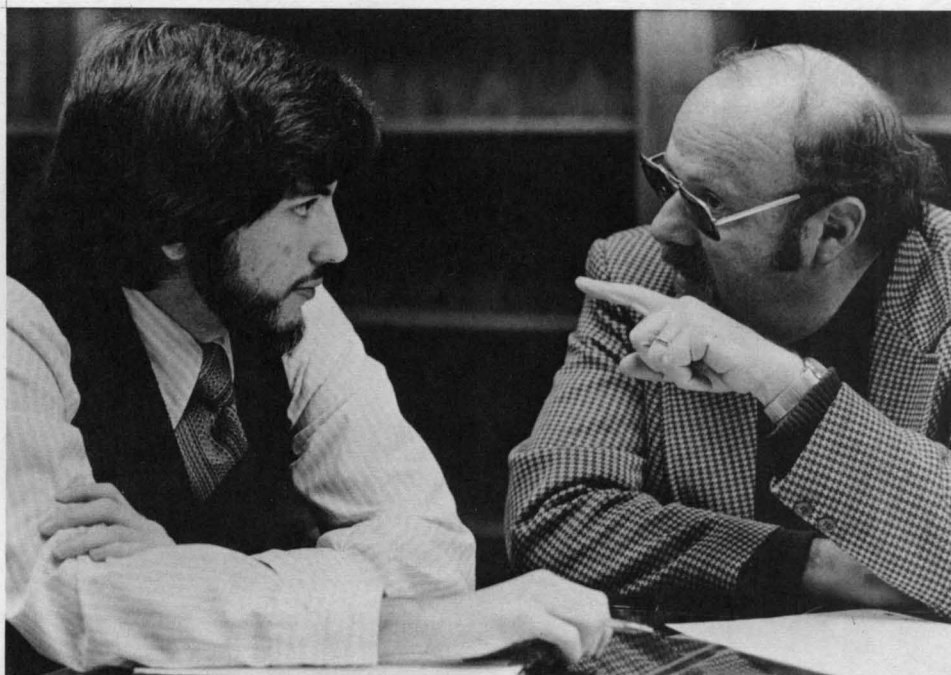
phase next year, we will meet the greatest challenge of all. There will be several tracks, and groups of students will choose to go one way while others elect to go in a different direction. This is the aspect of the curriculum which will enable Jefferson to maintain its progress in the specialty areas while still undertaking a new emphasis in general medical care. Imaginative development of these tracks will provide for the long-sought-after opportunity to bring advanced basic science education into the clinical years in a meaningful way. Thus programs with common basic requirements must be identified and brought together into a single track which provides opportunities for the student to major in more specific areas as he progresses. Planning for this kind of program is exciting, but it does represent a departure from the established methods of medical education with which we are comfortable. To be successful, therefore, the faculty must be willing to rise above biased interests and to give careful thought to the broad needs of medical care. Priority must go to the medical fields where

doctors are needed the most, and there must be some sacrifice in the areas which have been overemphasized in the past."

To determine whether our efforts are successful, we must measure the product. Associate Dean, Joseph S. Gonnella, is doing just that. The Department of Medical Education is acquiring data about our graduates which is already setting standards in other schools and in time will tell us how and where our curriculum should be altered.

So there we have it—a three phase curriculum involving four years. A curriculum that is flexible and yet not flimsy. One that can be improved as experience is gained, and one that can be evaluated to measure and retain that which is worthwhile; one that is designed to render better patient care in the oncoming decades.

In order to maintain its sanity, the Curriculum Committee has adopted the motto: "There has never been a medical school curriculum designed that has prevented a student from learning." We hope we are not setting a precedent.



*Dr. Alvin F. Goldfarb (right) discusses issue with second year student Neal Flomenberg.*



# The Affiliated Program: A Statement of Policy

*At its March meeting, Jefferson's Board of Trustees approved the following policy statement by the Committee on Affiliations. Members are John J. Gartland, M.D., Chairman, Robert L. Brent, M.D., Harry S. Goldsmith, M.D., John H. Killough, M.D., Ward D. O'Sullivan, M.D., Martha Southard, M.D. and Dene Thomas Walters, M.D.*

The community of hospitals that makes up the clinical teaching arm of the Jefferson Medical College is large. To meet the needs for clinical teaching, the Committee on Affiliations has developed an affiliated hospital program including fifteen area hospitals. The development of these affiliations has been facilitated by the simple fact that hospitals of high caliber have many goals in common with that of the Medical College. (See page 16.)

The affiliations program as envisioned requires a wide variety of different kinds of hospital affiliations and different community settings. The foundations upon which Jefferson's affiliation policy is built are twofold. It is felt first of all that a large number of hospitals rather than a small number provides a greater variety of educational experience for the students and trainees, and guards against overtaxing the teaching staff of the affiliated hospitals with large groups of students. Stability of the program would be maintained should one or two hospitals find it necessary to withdraw from the affiliation. Secondly, from Jefferson's viewpoint, all hospitals in the affiliated program have equal stature and share equal teaching responsibility. No hospital enjoys favored status over another in the affiliation policy as it is presently constituted.

Agreements between Jefferson and its affiliated hospitals are negotiated individually; no two are exactly alike. However, the differences that do exist between contracts are minimal and simply recognize that hospital administrative structures are not uniform. Certain items necessary for the smooth functioning of a joint educational activity are common to all agreements. These and other aspects of affiliation are considered at length during the joint development of a contract. In fact, the process of negotiation is more important in many ways than the final document itself. It is during development of the contractual descrip-

tion of the program, its mechanism, and rationale, that each group becomes aware of the desires and needs of the other and necessary compromises are made before affiliation begins.

An academic program director is appointed at each hospital, and, in addition, each department which participates in the affiliated program appoints an education director to relate to the corresponding department at Jefferson. Physicians from the hospital are appointed to the general faculty and to standing committees of the faculty so that they can participate in the educational planning process. They are appointed to the professorial faculty if they hold appropriate faculty rank. An associate dean is assigned to coordinate the affiliated program, and the faculty of the medical school is urged to make periodic visits to each hospital.

Following the national patterns of medical schools, Jefferson classifies its affiliated hospitals as those used for major teaching (type M) and those used for teaching only to a limited extent (type L). In 1973, Jefferson reported to the A.M.A. that it had sixteen affiliated hospitals: twelve type M and four type L.

Appendix A summarizes the bed capacities, the student assignments, the clinical services used and the percent of the total teaching hours which are conducted at each of the type M affiliated hospitals. These data have been taken from the assignments for the academic year 1972-1973, but it must be recognized that new factors are introduced each year which make it necessary to reduce student assignments and clinical services at certain hospitals while increasing them at others.

When the Committee on Affiliations reviewed its policies in 1968, it decided that increased emphasis should be placed upon affiliations with hospitals that are strong in many departments and, hence, could accept undergraduate students in several clinical disciplines. The committee also acknowledged the need for

students to have different kinds of educational experiences, and noted that community hospitals can often provide a better example of general medicine than a large academic medical center where many patients have uncommon and often complex diseases. The Wilmington Medical Center, Lankenau, Bryn Mawr, Mercy Catholic Medical Center, and the U.S. Naval Hospital are prominent examples of large institutions which can provide a great variety of educational experiences for the students.

Certain areas of medical education such as psychiatry, ophthalmology, and orthopaedic surgery require affiliation with hospitals of a single medical discipline. To meet the needs in psychiatry, relationships were developed at the Delaware State Hospital and the V.A. Hospital in Coatesville. The needs in ophthalmology were met by affiliation with the Wills Eye Hospital; and orthopaedic surgery had already met all its needs through affiliation with the Alfred I. duPont Institute and the Pennsylvania State Hospital for Crippled Children in Elizabethtown, Pennsylvania. Since Jefferson's curriculum needs to provide educational opportunities in hospitals which provide a greater orientation to their immediate communities, the Daroff Division of the Einstein Medical Center, the Methodist Hospital, and the Cooper Hospital and Our Lady of Lourdes Hospital in Camden have been added to the Jefferson affiliated program to fulfill this role.

In many of the Clinical Departments of Jefferson certain of the affiliated hospitals are utilized in the graduate medical training programs as regular rotations for residents. Advantages to both sides accrue from such a policy. Residents are exposed to greater variety of patient problems and teaching methods and Thomas Jefferson University Hospital tends to be regarded as a regional referral center for problem patients referred from the affiliated hospitals.

With awareness of the public con-

cern over the shortage of primary physicians and in recognition of its own responsibility to improve the availability of medical care, Jefferson has begun the development of a new teaching program in Family Medicine. Only one of the present affiliated institutions has an on-going family practice service—the Wilmington Medical Center. The Wilmington program can accommodate only four medical students. The need is for fifty students. The Committee on Affiliations will work closely with the Department of Family Medicine to assist in meeting the needs for a specified number of student physicians.

Agreements to affiliate will be negotiated with the other affiliated hospitals in this program as they develop family practice programs. In this manner the Committee on Affiliations hopes to be assistive to meet the needs of Family Medicine as well as the rural program which is now in the planning stage. An affiliation with Latrobe Hospital in western Pennsylvania already has been undertaken.

There is a need to develop a method for measuring the didactic programs, the acquisition of clerkship skills and the standardization of student evaluations. In the interest of helping to identify areas where educational efforts need to be intensified, the committee has begun to plan for a system of program evaluations on a department by department basis in Thomas Jefferson University Hospital and all other affiliated hospitals.

The two basic objectives of the program for 1974 are to meet the needs of the new Department of Family Medicine for teaching affiliations and to establish a program of evaluations to help identify areas where the clinical teaching of Jefferson might be further improved. By attending to these needs and insuring a strong and responsive affiliations program, Jefferson and its affiliate hospitals can maintain high quality medical education for our expanding student body.



## Appendix A

### CLINICAL TEACHING PROGRAMS

1972-73

	Beds	Students* Assigned	Clinical Services Used	Percentage of Total Clinical Teaching
Bryn Mawr Hospital	400	20	3	2%**
Cooper Hospital	600	52	6	6%
Daroff Division of Einstein Medical Center	250	32	4	3%
Delaware State Hospital	1,150	52	1	5%
Lankenau Hospital	400	111	8	12%
Mercy Catholic Medical Center	800	83	5	9%
Methodist Hospital	250	49	5	5%
Our Lady of Lourdes Hospital	330	8	1	1%**
Thomas Jefferson University Hospital	650	385	16	41%
U. S. Naval Hospital	1,000	45	3	5%
V. A. Hospital, Coatesville	1,550	49	1	5%
Wilmington Medical Center	1,100	57	7	6%

\* All student assignments converted to twelve week quarter

\*\* New program

New Affiliations are being activated with Chestnut Hill, Latrobe and Wills Eye Hospitals

### Goals of Affiliation

There is considerable commonality of goals between a medical school and its affiliated hospitals. Indeed, the chief difference exists not in the stated goals, but in their order of rank. All wish to advance education, research, patient care, and community service, but all recognize that the first purpose of the medical school is education and that of the hospital patient care. To some extent, the purposes of an affiliation are separate to the medical school and affiliated hospital, and to another extent they are mutual. In the following list, goals are assigned on a priority basis in an effort to emphasize what differences there may be in approaching affiliation:  
For the medical school:

1. To make available more patients for the education of students and to enlarge the medical school

faculty.

2. To provide the medical student with educational opportunities different from those of the university hospital.
3. To broaden the perspective of the medical school faculty and students through contact with physicians who are practicing exemplary medicine in a community environment.

For the affiliated hospital:

1. To maintain and promote the highest standards of patient care.
2. To support the recruitment and education of interns and resident physicians.
3. To advance the prestige of the institution in its community.
4. To obtain accreditation for the continuing education programs of its professional staff.

5. To strengthen its appeal for outside grants to support research and services programs.
6. To relate its investigative programs to the research facilities of the medical school.

Purposes common to both:

1. To provide for an on-going interchange of information between the medical school faculty and the hospital staffs, and thus improve the quality of medical education and patient care.
2. To engage in joint planning for the needs and demands of various non-medical groups at community and government levels.
3. To share expensive facilities for patient care and thus make the most modern methods of treatment available to all the patients of the affiliated hospitals.

# Lankenau: A Suburban Affiliate

by  
**Franz Goldstein, M.D. '53**

Jefferson's affiliate-associated hospitals have long provided Jefferson medical students with a substantial amount of their clinical training and education.

An informal affiliation between Jefferson and Lankenau Hospital began in 1949, when Lankenau Hospital was an aging Victorian edifice at Girard and Corinthian Avenues. In 1953 Lankenau moved to modern Vincent Kling-designed quarters at a new location off Lancaster Avenue just past City Line on over eighty acres formerly occupied by a country club. The informal arrangement for clinical training of Jefferson students at Lankenau was changed to a more formal agreement in 1968.

In the opinion of many, Lankenau today combines the best of two worlds, clinical and academic. It is a 425-bed community hospital with a broad mixture of patients from all strata of society. The hospital was founded in 1860 as "The German Hospital of the City of Philadelphia," designed primarily to render care to the then growing German population of the city. Lankenau is still oriented primarily towards patient care, but it also recognizes that first-rate care cannot be rendered without a commitment to teaching, education and clinical investigation. In this era of accountability to the community of consumers and patients, we feel strongly that the patient is best served in a hospital that has a strong house staff of bright young men and women, eager to learn and to do, and satisfied that their educational needs are met. Such a house staff can only be recruited when the hospital has an attending staff willing and able to give of their time and share their knowledge and experience.

Lankenau Hospital has long recognized its obligations to its patients to provide just this kind of environment. The hospital appointed its first resident physician in 1866; he also served as apothecary. In 1877, the complement of residents was doubled, from one to two, and the amended charter of 1882 specified that: "The said Corporation is also authorized and empowered to establish, in connection with a Hospital, a department for the education of students in the science of medicine."

The emphasis on patient care and medical education, for so long stressed at Lankenau, has produced an environment highly favorable for medical students. The bi-directional flow of knowledge and learning that exists between student and teacher is well appreciated by Lankenau's present staff who welcome medical students, find them stimulating and challenging, and find gratification from helping with the education of the young generation of new physicians.

The house staff also participates actively in student teaching while students participate in patient care, and a true camaraderie exists between medical students and house staff. At present, Lankenau Hospital has close to sixty house staffers, mostly residents, distributed according to relative patient numbers among the major divisions of medicine, surgery, obstetrics and gynecology and pathology in approved training programs. (Medicine, surgery, etc. at Lankenau are divisions: the subspecialties constitute departments or sections; thus the designations of divisions and departments are the reverse of their Jefferson counterparts.)

Many of our house staff come from



*Dr. Goldstein received his first Jefferson appointment in March, 1957 and was promoted to Professor of Medicine in July, 1970. He is Chief of Gastroenterology at Lankenau Hospital. Blanche Day, Director of Public Relations at Lankenau, assisted with the historical materials.*

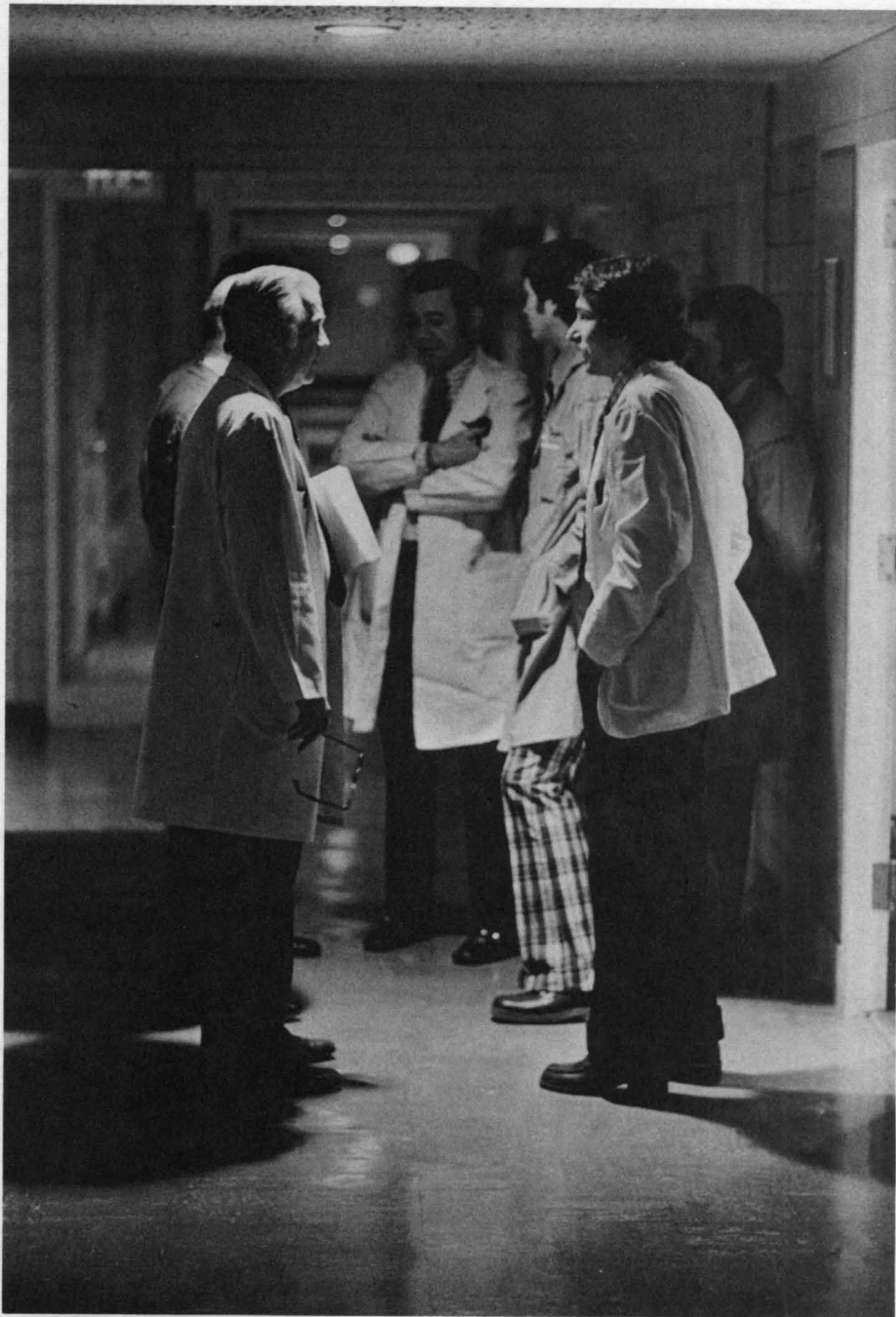


an ever-widening radius of mostly American medical schools with a sprinkling of foreign schools. Close to fifty percent of the house staff is recruited from among Jefferson graduates. Many of the Hospital's early resident physicians were Jeffersonians as well. One of the first was Dr. Marcus Franklin (JMC 1870) who later became an attending physician and claimed to have performed (in 1880) the first vaginal hysterectomy in Philadelphia and probably in the U.S. He also claimed to be the first to use salicylic acid in the treatment of rheumatism and the first to treat alcoholic insomnia with chloral hydrate.

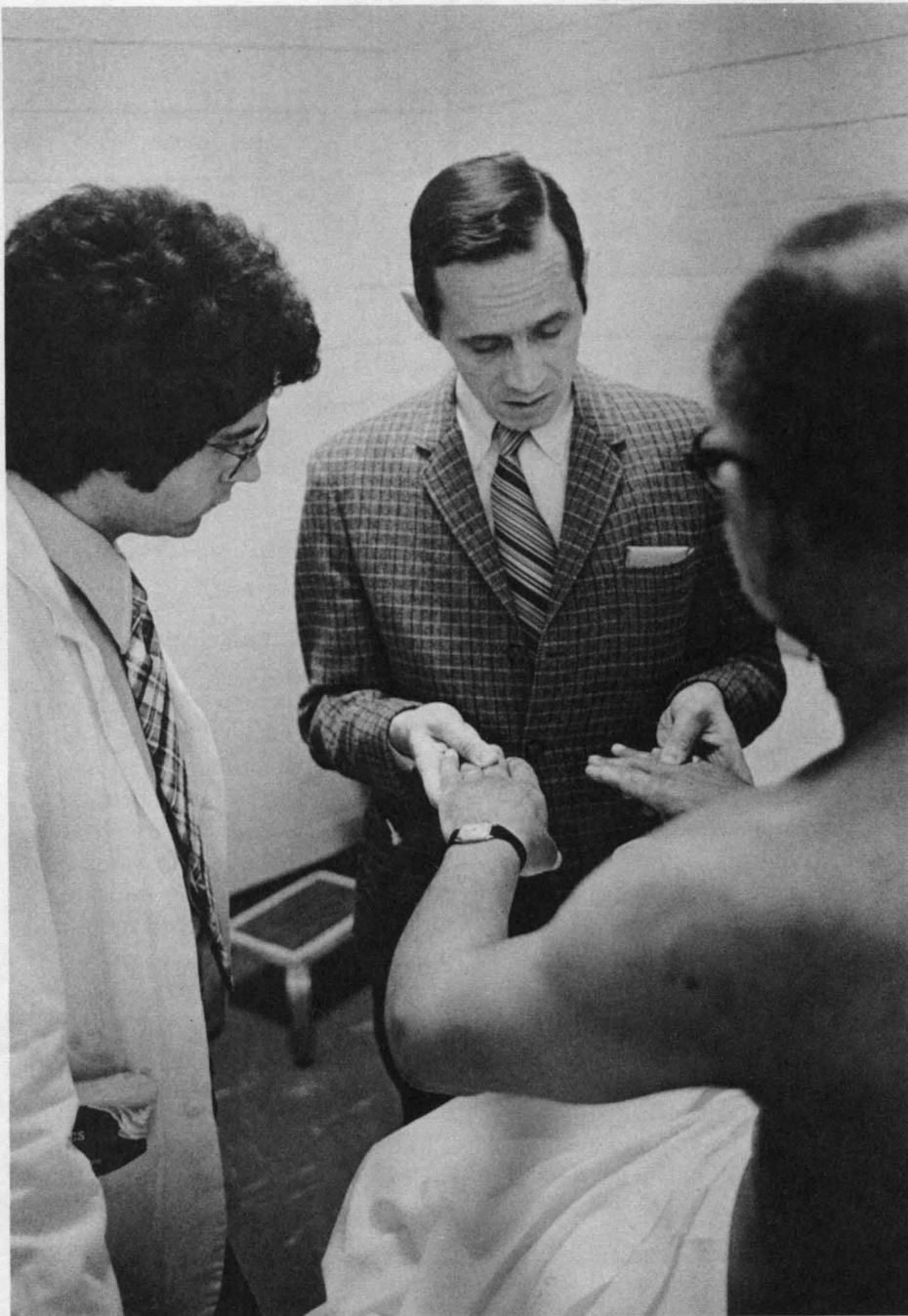
Also prominent in nineteenth century medical circles was Dr. Lambert Ott (JMC 1878), first a resident, then staff member, at the German Hospital. Dr. Ott was particularly interested in nervous diseases. He wrote numerous papers on the subject including "The Delirium of Convalescence" and "Fifteen Years Observations in Beer Drinkers." Since the hospital admitted many patients from the big breweries—men who usually consumed large quantities of their product—he found ample material for the latter paper at the German Hospital.

Another famous nineteenth century Jefferson alumnus and Lankenau intern was Dr. Victor G. Heiser (JMC 1897) who carved a prominent niche for himself as a pioneer in public health work and authored a best-selling autobiography about his worldwide adventures, "An American Doctor's Odyssey." Dr. Heiser continued to crusade against ignorance and neglect in the public health field until his death in 1972, aged ninety-two. He last visited Lankenau in 1968. The list of prominent, more recent Jefferson alumni who took some of their post doctoral training at Lankenau would be a long one.

The attending staff of approximately two hundred physicians has twenty-seven Jefferson alumni among its members with a broad mix from other medical schools. A substantial



*Dr. Edwin W. Shearburn (left), Chief of Surgery at Lankenau, on early morning rounds with Jefferson students. Dr. Shearburn holds the rank of Professor of Surgery.*

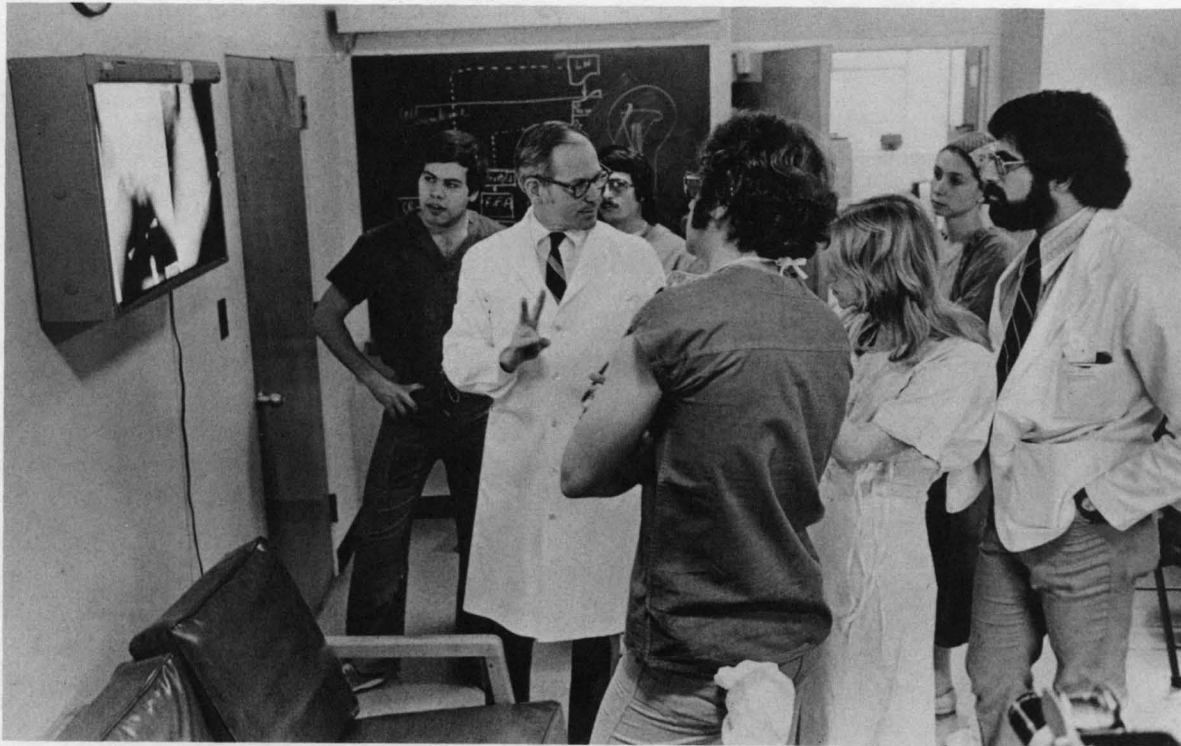


*Dr. Michael A. Manko with third year Jefferson student Ted Feinstein is Director of Medical Education at Lankenau and Clinical Associate Professor of Medicine.*

number of staff physicians had their residency training at Jefferson. While the majority of staff have teaching appointments at Jefferson, and new staff appointments as a rule are conditioned upon obtaining a faculty appointment from Jefferson, a number of the present staff have other medical school affiliations. The broad background of the staff doubtlessly is an asset to all, and medical parochialism is conspicuously absent at Lankenau. The staff of Lankenau is truly distinguished and has many physicians with national and international reputations. Others confine their activities to Lankenau where they make unheralded but equally important contributions to patient care and teaching. It would be tempting to list the "stars" of the staff, but this would undoubtedly leave out others of equal merit and therefore no list is provided. Most physicians have offices in the Lankenau Medical Building, part of the hospital complex, and are thus available and on the premises most of the time.

Lankenau's size is a distinct asset. The number of beds available makes it economically possible to provide almost all useful patient services. Thus Lankenau has both a surgical and medical intensive care unit, the latter particularly geared to coronary care; a renal dialysis unit; specialty laboratories in the pulmonary, gastroenterology, neurology and hematology departments, and other specialized units and services. Retinal surgery of highest caliber is available. Open heart surgery and renal and hip transplant surgery are being successfully performed at Lankenau. Yet, the size of the hospital is small enough to promote close interpersonal relationships. Indeed, one of the favorable comments frequently received from students and house staffers alike is that they come in close daily contact with all levels of attending staff, including the chiefs. An informal atmosphere prevails in conversations, and most attending staff know the house staff by their first names. While students remain on service for shorter





*Dr. Kaighn Smith, with medical students and house staff, is Director of Obstetrics and Gynecology at Lankenau and an Associate Professor at Jefferson.*

and variable lengths of time, they, too, become known to many attendings and close personal ties are often formed.

In addition to daily discussions of patients on floors, more formal teaching sessions are regularly scheduled. The didactic lecture format is not necessarily adhered to, and emphasis is placed on discussion of patients and diseases in whatever setting is considered most appropriate by the individual instructor. Liaison is maintained with the department and division heads at Jefferson's main campus to coordinate the teaching within the guidelines of Jefferson's curriculum for medical students. Clinical rounds are held primarily for the benefit of the house staff, but medical students are always welcome and usually present. Each major division and department has weekly Grand Rounds or clinical conferences for the benefit of attendings, house staff and students. Guest speakers are frequently invited, especially for the Grand Rounds. The Director of Medical Education oversees and coordinates the numerous educational

activities. A total of thirty-three different conferences are approved for Category I credit.

With Jefferson's expanding student population and shrinking bed capacity, the school has had to depend increasingly upon associated hospitals to provide clinical teaching. We at Lankenau at any given time accommodate over thirty students, mostly juniors and seniors, on regular core block rotations as listed below. Six-week electives are available in medical subspecialties. Electives can also be arranged in the divisions of surgery and its subspecialties, in obstetrics-gynecology and in emergency room medicine. During any given block, we have between five

and ten students on electives. During the winter and spring semesters, sixteen sophomore students are assigned to Lankenau for physical diagnosis, a demanding and time-consuming effort on the part of the staff. Students are on rotation throughout the year, including the summer quarter. Junior students receive tutorial instruction and a full set of programmed instruction in each assigned division. We also occasionally draw students from other medical schools for electives, both from the city and from far away. All students on regular rotation are asked to provide critical comments about their experiences at Lankenau. These comments are carefully studied and

Present Number of Students	Service	Period of Time
8	Junior Medicine	12 weeks
5	Senior Medicine	6 weeks
4	Senior Neurology	3 weeks
2	Senior Neurosurgery	3 weeks
4	Junior Obstetrics-Gynecology	6 weeks
4	Senior Orthopaedics	2 weeks
4	Junior Surgery	12 weeks



*Student makes presentation during conference with Director of Medicine Dr. Frank D. Gray, Jr. Dr. Gray is Professor of Medicine.*

every effort is made to remedy shortcomings. It is gratifying to report that the vast majority of comments are laudatory and often quite enthusiastic.

It is similarly gratifying to note that the instructors' comments about students are also mostly laudatory and that students of today are found to be highly intelligent and just as eager to learn as their predecessors were. Even during the recent years of alleged student rebellion, we found very little to support the rumors of student indifference or of a diminished urge to learn. The staff, for its part, has grown accustomed to new styles in coiffure and dress, but the hospital rules demand, in the interest of patients, adherence to accepted standards of hospital dress and professional conduct.

Lankenau has a separate division of research, funded from outside sources and not from patient revenue. The division has an annual budget of approximately one million dollars and engages in both basic and clinical investigation. In addition to its full-time staff, the division has many of the hospital's clinical staff on its roster, thus fostering an interaction between

researcher and clinician. House staff and students have the opportunity to participate to a limited extent in research activities. The main thrust of the division is in the area of lipid metabolism and coronary disease.

The nursing staff and nursing school deserve an extra pat on the back. Undoubtedly helped by its location, Lankenau has continued to attract sufficient numbers of highly qualified nurses and nursing students who practice the nursing profession with skill and grace and constantly come in for praise from patients and physicians alike.

Lankenau has an active Board of Trustees, cognizant of their responsibilities towards the community, responsive to the needs of patients and willing to give freely of their time to work with the hospital administration and hospital staff to make the complex hospital machinery work, to balance budgets and satisfy seemingly incompatible interests of patients, their insurers and their physicians. The chairman of Lankenau's Board of Trustees is a member of Jefferson's Board, thus making the affiliation work smoother.

If all the above sounds like utopia, it isn't. As in all human ventures, there are constant problems to solve, different approaches to problem solving suggested, and differences of opinion to reconcile. As Lankenau provides more than most community hospitals towards the education of medical students and receives no reimbursement for its efforts, the question of who should pay for medical student education is often heard. This is not the place to discuss it, but it is worth mentioning that this issue has not been satisfactorily resolved. Lankenau Hospital does not share in the educational funds channeled to medical schools. Other associated hospitals face the same problem.

Lankenau Hospital, its Trustees, Administration and Staff, share the pride in the hospital's past accomplishments and its past and present ability to adapt to changing times and requirements. All of us have confidence that with effort and good will we can meet future obligations and challenges with the same skills and success with which our predecessors have met past challenges.



## An Evening of Nostalgia



*Lincoln Hall at the Union League of Philadelphia was the setting for the March 1 Sesquicentennial Dinner.*

March 1 truly was a special night. Dr. Paul A. Bowers '37, presiding at his last meeting as President of Jefferson's Alumni Association, had called for a different treatment of the Annual Business Meeting to honor Jefferson's Sesquicentennial. To accomplish this he extended the Association's invitation to the teachers and alumni who have brought honor and distinction to their school: the Emeritus Professors and the recipients of the Alumni Achievement Award.

Seventeen were present at the black tie dinner at the Union League of Philadelphia. Dr. George C. Griffith

came from California. Dr. Louis H. Clerf and Dr. Philip J. Hodes came from Florida. The few who were unable to attend due to illness or international meetings sent their regrets and greetings.

It was a time for renewing old friendships, seeing colleagues and classmates and meeting the Professors. It was a warm and memorable evening. Dr. Bowers brought Lincoln Hall to its feet for the first time when he proposed a toast to "the man who made it all possible," George McClellan. The all male audience of two hundred rose seventeen addition-

al times to acknowledge the President's introductions of those special guests (see photo spreads). Speakers on this historic occasion were two recipients of the Alumni Achievement Award, Dr. Henry L. Bockus and Dr. Francis J. Braceland. Representing the Jefferson administration was Dr. Peter A. Herbut, President of Thomas Jefferson University. Dr. Bockus and Dr. Braceland served Jefferson as the first Alumni Trustees. One letter of thanks seems to sum up the general response to the occasion, . . . "a perfectly brilliant evening full of nostalgia and promise."

# Basic Sciences in the Medical School's Future

by Robert H. Ebert, M.D.

My personal crystal ball is as murky as the next man's and I make no pretense of being able to predict the future of medical education in general nor basic science teaching in particular during the next decade. But there are certain trends which are self-evident, and what I propose to do today is to examine some of these trends and extrapolate from them as best I can in an attempt to form some judgments about what *might* happen. Let me re-emphasize that I will only indicate what *might* happen and not what *will* happen for trends can be reversed rapidly and events which are totally unpredictable could have a profound impact on medical education. In following this script I shall touch on a great many issues which appear to be peripheral to the topic I have chosen, namely, the future of the basic medical sciences. Yet, in one way or another, they all impact on that future—some directly, but more often indirectly.

## Health Manpower

In the January 1974 Bulletin of the Association of American Medical Colleges (vol. IX, no. 1), the following statement was made about medical school enrollment:

"A total of 50,716 students were enrolled in one hundred fourteen U.S. medical schools in the 1973-74 academic year, representing the expansion of about 13,000 over the past five years. The larger enrollment resulted from thirteen new medical schools together with enlarged classes in previously established schools. The total medical school enrollment represented a gain of 3,350 or 7.1 percent over 1972-73, when there were one hundred twelve medical schools."\*

In other words, over a five year period, expansion of total medical school enrollment there had been an almost thirty-five percent. This is an impressive increase and is the culmination of a national concern for what the Congress and the public perceived as a growing shortage of physicians. What in fact occurred, was a shortage of medical services, but quite naturally, this was interpreted to mean a shortage of physicians, even though there were many observers who pointed out that the problem of shortages related more to the organization of the medical care system than to a shortage of medical manpower.

The expansion was accomplished by liberal financing of new medical school con-

struction and by federal funding of existing medical schools linked to increase in class size. The availability of new funds for construction has dwindled to almost nothing over the past five years, and now it appears that funding linked to increased enrollment is being seriously questioned. In the fall of 1973, Dr. Charles Edwards, Assistant Secretary for Health, gave a thoughtful and provocative speech at the annual meeting of the American Association of Medical Colleges which was a clear statement of a new administration policy for health manpower. He pointed out that if we simply maintain our current output of health professionals, we will have fifty percent more physicians by 1985 and that if the influx of foreign medical graduates remains constant, there will be two hundred twenty doctors for 100,000 people by that date compared with one hundred sixty in 1970 and one hundred forty in 1960. He then made the following highly significant remarks and I quote:

"If you regard the last decade of Federal support of health manpower training as having the goal of turning out more physicians, dentists, nurses, and allied health professionals, then you would have to conclude that these efforts have been highly successful.

"But if you look at health manpower development efforts as part of a broader national purpose—namely to make health services available to everyone at a cost that both the individual and the society can afford—then it is clear that all of us—not just government, but the whole health community, public and private—have to reassess our priorities in the manpower field and perhaps adopt some fundamentally different ones.

"I am not at all sure that a further increase in our capacity to train physicians is in the best national interest at a time when population growth rates are declining and there is ample opportunity to expand the productivity of practicing physicians."

This is a most important statement and one with which many thoughtful students of the problem would agree. Even if one assumes that anything proposed by the current administration will automatically be resisted by the Congress, it is unlikely that there will be enormous pressure to continue the increase in medical school enrollment. Medical schools have had difficulty in adjusting to the current increases and will not lobby for more students. Organized medicine is unlikely to do so and consumer groups are more likely to be interested in adequate insurance and cost control. While the full impact of increased enrollment will not be apparent for some years, it can be demonstrated that new manpower is in the pipeline and that further increase will

\*Bulletin of the Association of American Medical Colleges. IX (No.1): 3, January, 1974.

*Dr. Ebert was at Jefferson to give the keynote address of the Biomedical Science Symposium planned in conjunction with Jefferson's Sesquicentennial. The address was given on Friday, March 8 in Jefferson Alumni Hall before a full audience. Dr. George F. Kalf, Professor of Biochemistry, was program chairman.*



have little effect on the current problem.

In my opinion, the commitment to increase further the enrollment in medical schools is at an end and that the trend will be toward consolidation of the expansion which has already occurred. There may even be the suspicion that we will over-produce M.D.'s during the next several decades and that better organization of medical services will make this evident. Even our heavy dependence on foreign medical graduates is unlikely to alter this trend. A substantial change in policy toward the emigration of FMG's would not alter the fundamental observation made by Dr. Edwards that we presumably have the capacity to produce all of the physician manpower we are likely to need for the next several decades. Most important is the impact of this trend on public policy on the financing of medical education. If the capacity of medical schools is adequate and there is a surplus of applicants from medical schools, it is unlikely that the federal government will offer any financial incentives to medical schools for recruitment or retention.

### Biomedical Research

Over the past several decades there has been a revolution in the biological sciences made possible in part, at least, by the advances in technology applied to biology. Molecular biology has been the spearhead of the conceptual advance and the approaches of this relatively new field are now being applied to more complex levels of biological organization. Molecular biology was an intellectual creation that came more from outside the medical establishment than from within, and attracted to biology some of the best scientific minds of a generation. Young men who in the past might have pursued scientific careers in the "purer sciences" of physics and chemistry now discovered that biology was an exciting scientific frontier and decided to become a new breed of

biologists. Once this had occurred it was not surprising that other fields of biology would be re-explored and probed with the powerful new tools available to the modern biologists. The result is that biomedical research is no longer the private preserve of the medical school and there is general university interest in such fields as cell biology, virology, human genetics, immunology, and neurobiology. Similarly, the clinical investigator has seized upon these new approaches to biology and it is not unusual today to find an internist, a microbiologist and a university based biologist working on the same problem and using the same technological tools. This eclectic approach to biomedical research has resulted in a natural confusion about the role of the basic medical sciences in the medical center. It is no longer possible to identify the departmental discipline of the individual by visiting his laboratory, and this fact has led some to ask if there is any particular reason to continue to support the traditional basic science disciplines in medical schools. Whatever the ultimate answer to this question, the present trend of broad university interest in biological and biomedical research is likely to continue. Certainly for the next decade or two, modern biology is likely to flourish and to continue to attract able young scientists. Some will work in departments of biology, some in basic science departments, some in clinical departments, and some in research institutes. But they will be concerned with many of the same problems.

There has been an important side effect of the biological revolution and that is that the technology required has become increasingly complex and the cost of equipping and supporting biological research has become greater. It becomes increasingly difficult for the isolated investigator with modest laboratory resources to compete with large scientific establishments and the trend is toward larger centers. This does not mean that the individual scientist is any less important today than he ever was in

the past, but his work is unlikely to flourish unless he has the opportunity for intellectual interchange with a critical mass of scientists interested in related problems and can share the cost with others of the expensive technology associated with modern biology. This is as true for the biologist in the faculty of arts and sciences as it is for the medical school basic scientist and is equally true in the clinic. The trend is in the direction of groups of scientists, not necessarily working as a team, but working in an environment of shared ideas and shared technology.

### Federal Financing

The federal government is at present the most important source of funding for the biomedical establishment and it is important, therefore, to consider future trends in the federal financing of medical education, including support of students, of biomedical research, and research training.

Since 1950, medical schools and teaching hospitals have received significant support via the funding of research and research training. This indirect support of medical education has caused many problems which I do not propose to discuss today, but from 1950 to 1968 it provided an ever-expanding base of financial support for pre- and post-doctoral fellows who participated in the teaching effort. In addition, the payment of overhead gave medical schools some flexible money which could be used for general cost including building maintenance and administration. The flattening of the growth curve in this indirect support of medical education caused great financial embarrassment because medical schools had become so dependent on an expanding research budget. A part of the financial crunch was eased by the introduction of a new means of direct support of medical education, namely, the capitation allowance. First introduced in 1972, it was tied to increase in class size, and eligibility was directly

*Dr. Robert Ebert has been Dean of the Harvard Medical School and President of the Harvard Medical Center since 1965. Prior to his Harvard appointment Dr. Ebert served as Chairman of the Department of Medicine at Western Reserve University and Director of Medicine at the University Hospitals. He has received honorary degrees from Harvard, Northwestern University, the University of Maryland and the University of Toronto. The University of Chicago where Dr. Ebert received his medical degree honored him with the Distinguished Service Award. The Harvard Dean was both a Rhodes Scholar and a Markle Scholar.*



linked to expansion. The capitation allowance provided approximately \$2,000 per student and a bonus was given for each additional place provided in the entering class. While the amount per student falls far short of the real cost, it provides an important base of unrestricted funds.

It now appears from the statement of Secretary Edwards that this trend may be reversed and capitation allowances will no longer be linked directly to expansion. Although the Bureau of Management and Budget opposes the idea, it is probable that some sort of capitation allowance will continue, but not without a quid pro quo. If we have learned nothing else about government support of medical research or education, it is that something specific is expected in return. It may be an emphasis on primary care; it may be the re-organization of medical services; it may be the distribution of specialists; or it may be something else. But rest assured it will be something. It seems inherent in our public policy that the direct support of medical education is too simple a concept for the Congress or the Executive to accept.

Tuition is a significant source of income to the private medical school and even in the state supported school the cost to the student is rising. The question is who will pay this cost, directly or indirectly. There is no evidence that in the future the federal government is likely to underwrite a large part of this cost in the form of direct scholarships even for the disadvantaged, and there are good reasons for this. First, there is a great reluctance to give scholarship support for the education of professionals who, in the future, will be the highest earners in the country. Second, there is no shortage of applicants to medical school and no need to provide a financial incentive for recruitment. The trend instead will continue in the direction of federally guaranteed loans. There may even be pressure on medical schools to increase tuition charges so that the student bears a greater part of the cost of his education.

What about the federal support of biomedical research—what are the apparent trends? There does not appear to be any change in the categorical approach to biomedical research support—indeed, it appears that it will be emphasized even more in the future. This is already true in the case of cancer research, and heart disease research seems likely to follow the same lead. There are certain consequences of this trend to concentrate research money in a categorical fashion. First of all, there will be less money for the direct support of basic biological research. This does not mean that fundamental research will have less total support, but a part at least will come from categorical grants. Second, there will be an increase in the use of large center grants which place under a broad financing umbrella a variety of research programs both basic and applied. Third, these center grants will tend to go to universities or institutes where there is the largest concentration of biomedical scientists. This will accelerate the trend toward further concentration of research talent and money in fewer institutions. Fourth, large

disease oriented categorical research center grants will not automatically go only to medical schools and medical centers but to university faculties of arts and sciences as well. M.I.T. is currently the recipient of a large cancer center grant because the scientific talent exists there in biology to contribute to the solution of the cancer problem.

I mentioned earlier that research money will be less reliable as a means of supporting medical education in the future because of the flattening of the growth curve. Increasing support of large research center grants will accentuate this trend since there will be less money for individual investigators. Competition among institutions will replace to some degree the competition among individual investigators.

While there has been a reprieve in the cutting of research training grants it is unlikely that there will be an unqualified return to past policy of pre- and post-doctoral training support. It is far more likely that research training will be supported in association with large categorical center grants with the largest amount of money given to training in the fields of cancer and heart disease. Again, training programs are likely to be concentrated in fewer centers than in the past.

In summary, federal financing will no longer be the open-ended source of medical school funding in the immediate future.

### State and Private Financing

Between 1950 and 1968, state governments came to rely heavily on federal funding of research and research training in state medical schools. As noted earlier, such funding contributed in a significant degree to the general support of state medical schools. This posture is unlikely to change and state legislators will not vote funds to support research and training activities previously funded by the N.I.H. Indeed, state legislatures will be disinclined to increase support for state medical schools unless such support is tied to solving problems such as the maldistribution of physicians, particularly in rural areas and the shortage of family physicians. In other words, there is no evidence that state governments will provide liberal unrestricted support to state medical schools in the next several decades.

The private sector does not promise to be any more liberal than state government in the unrestricted support of medical education. Large foundations have not given much support to biomedical research during the past several decades because the contribution of the N.I.H. was so large and this policy is unlikely to be reversed. It will not change partly because the resources of private foundations cannot begin to match federal funding and partly because most large foundations are interested more in the social problems of medicine than in biomedical research; nor does there appear to be any interest in the support of medical education per se.

Large corporate industry is increasingly concerned with the overall cost of medical care since it pays a substantial share of the cost. Therefore, what money it gives to

medicine is more likely to be directed toward programs designed to develop a more rational health system than toward the general support of medical education. Except for a few health related industries, there is little interest in the support of biomedical research or research training. There are, of course, large private fortunes often associated with the profits made from the corporate world, but there are a variety of supplicants for financial help from private donors and there will continue to be substantial competition for these dollars. Finally, there is the money distributed via the voluntary health agencies but there is no evidence that there will be a significant increase in this source of funding, and much of this money now finds its way into medical schools.

### Trends Influencing Medical Education

The interest of the non-medical school faculty in problems of biology which in the past were the primary concern of the medical faculty has naturally led to increased student interest in human biology. This together with the striking increase in the number of pre-medical students has stressed the resources of the university to meet new demands for new courses in biology as well as the more traditional pre-medical courses. The increase in the number of pre-medical students is probably due to a complex of reasons, including the decline in the job market for Ph.D.'s, the financial security of the M.D., the variety of careers open to the M.D., and the opportunity to combine an interest in science with service to the community. It may also reflect the realization of many college students that a B.A. degree has lost much of its value as a qualification for jobs after graduation. But whatever the reasons it does not appear that student interest in medicine as a career will slacken in the near future.

I have not discussed the financing of the general university, but if anything, the parent university has been harder hit by the financial crunch than the medical school. Fiscal constraints in both private and public universities, added to the increased demand for the teaching of biology, will lead to a re-evaluation of the distribution of faculty resources in biology throughout the university and will force consolidation of resources in areas of instruction which appear to be overlapping.

The cost of education, both undergraduate and professional, has become a formidable problem for all but the wealthy. A family income of \$25,000 to \$30,000 a year is no longer adequate to pay for two children in private college or medical school at the same time without some form of financial aid and even state supported higher education has become expensive. Added to this has been the effort of colleges and medical schools to recruit from the disadvantaged in the population with the result that there has been an increasing demand for scholarships and loans. Quite naturally, this has led to a re-examination of the length of the educational process. Is there anything magic about the four year requirement for the B.A. degree?



Can the M.D. degree be done in three years, as well as in four? Can there be time saved by combined undergraduate and professional education with six years devoted to undergraduate and medical school education rather than the traditional eight years? There have been experiments in all of these areas without any clear cut trend as to what may evolve as the standard pattern. But increasing cost will probably force some kind of shortening of the education of the physician.

### **Impact of these Trends on Medical Education**

Let me reiterate my disclaimer as a prophet, and state again that what I have to say now may prove quite wrong. But it is difficult not to draw certain conclusions from the trends I have noted. The conclusions are as follows:

1. We are entering a period of retrenchment in medical schools and medical centers. Even though there may be some further expansion in the size of medical school enrollment, there will not be a corresponding increase in financial support. I say this because of the fiscal constraints which I outlined earlier plus a continuing inflation which seems uncontrolled and which hits universities and medical schools particularly hard. The plateauing of research funding will not be replaced by an increase in general support of medical education. There is the growing suspicion of both federal and state government that more money for medical education will neither improve the quality of care nor solve the problems of maldistribution of care. The private sector seems disinterested in coming to the financial rescue of medical schools, and there will be more resistance on the part of third party payors to the support of clinical faculty in teaching hospitals. Retrenchment will be evident in a number of ways:

- a. There will be a reduction in the size of the full-time medical faculty which devotes itself exclusively to medical school affairs. In some schools, there will be an absolute reduction, while in others the medical faculty will be called upon to do additional teaching which may be to undergraduates or allied health professionals.

- b. There will be a reduction in the size of the full-time clinical faculty devoted to teaching and research. In part, this will take the form of a shift in function with more time spent in clinical service.

- c. A number of medical schools have been close to bankruptcy during the past five to six years and have always been saved by special federal appropriations. The rationale was that the nation could not afford to have a medical school close during a period of physician shortage. There is the distinct possibility that in the future, medical schools in financial difficulty, particularly those that are marginal, will be allowed to close.

2. There will be a concentration of major research activities in fewer institutions. For years, the conventional wisdom stated that research, education, and patient care were inseparable and that one needed all three in order to teach medical students. This, in part, was the rationalization for the indirect support of medical education via the re-

search dollar. It is no longer an acceptable policy to use research funds as a major source of funding for education so that a wider institutional distribution of research money is no longer deemed necessary. This, together with the trends in research funding noted earlier, will tend to further concentrate research programs.

3. Medical school curriculum design will become more conservative. We have gone through a period of more than two decades during which experimentation with the educational process and curriculum design has been fashionable and encouraged by both foundations and federal subsidy. It seems probable that this period is coming to an end and that there will be little federal subsidy for general experimentation. What subsidies there are will be directed toward shortening the educational process and encouraging the production of primary care physicians. There will be less incentive to provide the medical student with a varied experience and elective time will be more structured. With reduced resources there will be greater concentration on the fundamental needs of the practicing physician, namely, a solid basic science background and good clinical experience.

4. There will be a consolidation of medical school basic science departments with faculty of arts and science departments where feasible. At the very least there will be shared teaching responsibility across faculty lines.

5. There will be shortening of the educational process leading to the M.D.

6. The cost of the educational process will put state medical schools in a favored position for the recruitment of the best students if the tuition costs are kept much lower than in the private school.

### **Who will Teach the Basic Sciences?**

An increasing interest of the faculty of arts and sciences in human biology, together with the need to conserve resources, could lead to a radical change in the pattern of medical education. The medical school as we know it could disappear to be replaced by the faculty of arts and sciences teaching the basic medical sciences to undergraduates and the teaching hospitals becoming responsible for pathophysiology and clinical training. In other words, a pattern could develop not unlike that which existed for many years between Oxford University and the hospital medical schools in London. One cannot exclude this as a possibility, but in my opinion, it is unlikely to evolve, at least during the next decade. The reasons are as follows: It is difficult to change the long tradition of the separate medical school which has been accentuated by the development of the so-called medical center. Secondly, the split could really occur only within universities which presently have medical schools. Universities without medical schools are not prepared to provide the range of basic science teaching needed. In addition, there would be no easy way to arrange for acceptance of students completing the basic science requirements into teaching hospitals without an identifiable faculty of medicine.

There is a second possible departure from the traditional medical school model which is equally radical. The medical center teaching hospital complex even more loosely associated with the university, could take over the total education of the physician with truncated basic science departments and much of the basic science teaching done by the clinician. Again, this is possible, but in my opinion, unlikely to happen. Here the barriers of tradition are less strong since some medical school medical centers are already geographically detached from the parent university, and clinicians are presently engaged in teaching a part of the basic sciences in so-called integrated curriculums. I think it will not happen for other reasons. Medical centers are experiencing too many other pressures at the moment to wish to take on this additional burden. The provision of primary care to the surrounding community, the need for better quality control, the demand for continuing education, and the constant rise in costs are more likely to preoccupy the medical center than the provision of a complete medical educational environment. In addition, the trend toward a reduction in the number of full-time clinicians with a commitment to research and teaching makes this option less likely. Finally, the university is unlikely to delegate to an institution increasingly detached from the academic environment the privilege of granting an advanced degree.

If these more radical changes are unlikely to occur, then what will be the pattern of basic science education during the next decade and what will be the organization of the medical school? Probably, there will be the preservation of a faculty of medicine, even though some departments may do double duty in teaching undergraduates and medical students. The basic medical sciences will not simply be absorbed into the faculty of arts and sciences—indeed, the consolidation of resources is likely to go the other way. Departments of biochemistry, microbiology, physiology (including neurobiology), and anatomy may well become more and more involved in the teaching of undergraduates but they will maintain their identity with the faculty of medicine. I say this because there continues to be the need for disciplinary teaching in medical schools, while the teaching of undergraduates or even graduate students in biology requires no such disciplinary approach. It is quite possible that students entering medical school who have completed some requirements in college will be given advanced standing but this will be at the discretion of the faculty of medicine.

The years ahead will not be easy and there will be many who decry the degradation of medical education. But whatever our personal feelings, it seems wise to accept the reality of the present and the immediate future. The day of continuous expansion of resources is over. Medical schools and universities can rise to this challenge by creating the best educational environment for students that can be accomplished within the constraints of our resources. That, after all, is our primary function which must supersede all others.



*Dr. William T. Lemmon '21 (seated center), Emeritus Professor of Surgery, receives an ovation from colleagues. He served as Professor from 1949 to 1962.*

*Table number one: from left Drs. Harold L. Stewart '26, George C. Griffith '26, Bernard J. Alpers, Thaddeus L. Montgomery '20, Henry B. Decker '20, Edward L. Bauer '14, David M. Davis, Baldwin L. Keyes '17, and Louis H. Clerf, '12. Dr. Davis was named the Nathan Lewis Hatfield Professor of Urology in 1946 and served as Chairman from 1935.*

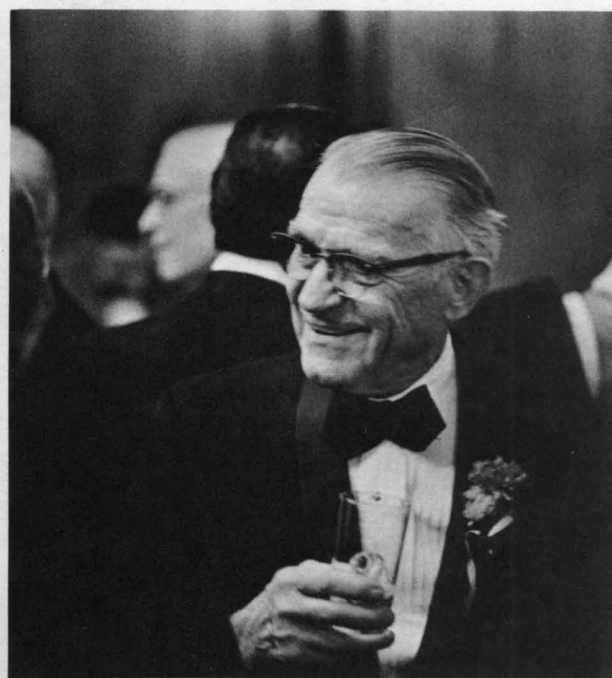


*Dr. Philip J. Hodes acknowledges his introduction as Emeritus Professor of Radiology. A 1931 graduate of the University of Pennsylvania School of Medicine, he was named Chairman of the Department at Jefferson in 1958.*



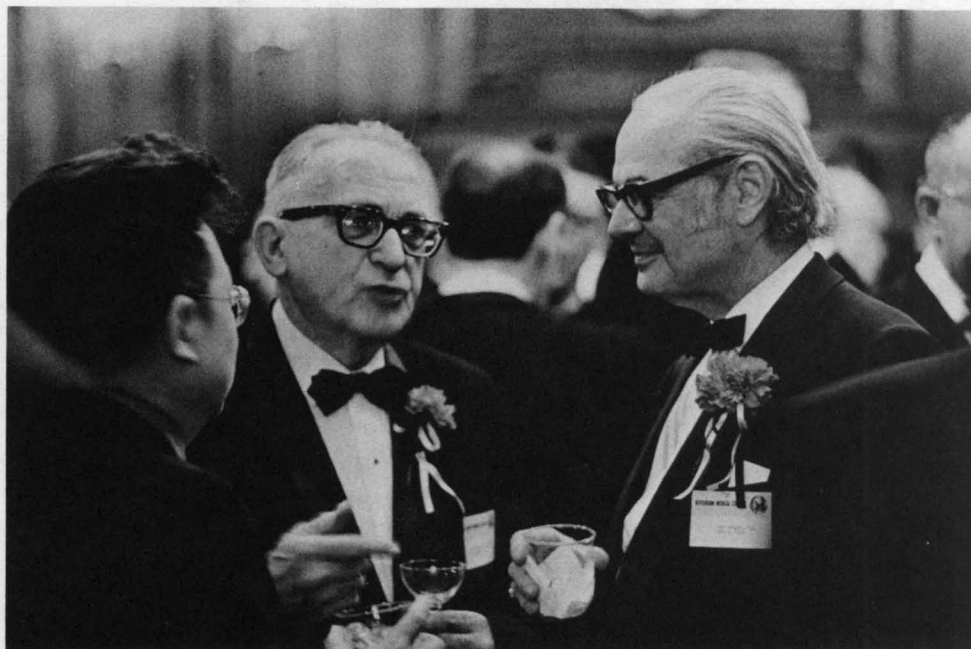


*The three B's: from left, Dr Francis J. Braceland '30, banquet speaker, first Alumni Trustee and Alumni Achievement Award recipient. Dr. Braceland is Senior Consultant at the Institute of Living in Hartford, Connecticut. Alumni President Paul A. Bowers '37. Dr. Henry L. Bockus '17, banquet speaker, first Alumni Trustee and recipient of the Alumni Achievement Award. He is Emeritus Professor of Medicine at the University of Pennsylvania Graduate School of Medicine.*

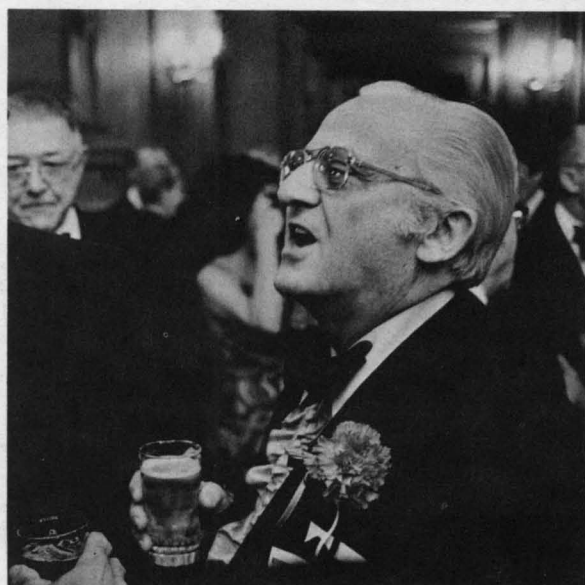


*Dr. Louis H. Clerf '12, above, Emeritus Professor of Laryngology and Broncho-Esophagology and first recipient of the Alumni Achievement Award. Dr. Clerf, a past President of the American Laryngological Association, retired in 1954 and is residing in St. Petersburg, Florida. At left from left, three recipients of the Achievement Award, Dr. Harold L. Stewart '26, Chief of the Laboratory of Pathology at the National Cancer Institute since 1939; Dr. George C. Griffith, '26, Emeritus Professor of Medicine at the University of California School of Medicine and Dr. George C. Willauer '23, Honorary Professor of Surgery at Jefferson.*

*Dr. Bernard J. Alpers (center), Emeritus Professor of Neurology, was appointed Chairman in 1938. He is a past President of the American Board of Psychiatry and Neurology and the American Neurological Association; and Dr. Fred Harbert (right), Emeritus Professor of Otology, a post he held from 1954 till retirement in 1970. He is a retired Captain in the U.S. Navy.*



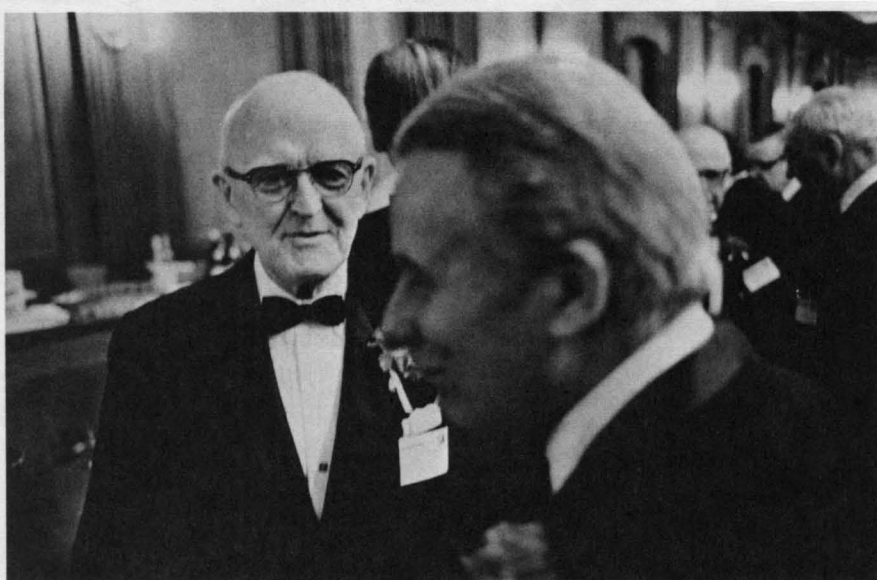
*Dr. Thaddeus L. Montgomery '20, was named Professor and Chairman of Jefferson's Department of Obstetrics and Gynecology in 1946 and served until 1961. Dr. Montgomery received the Achievement Award in 1970.*



*Dr. William A. Sodeman, left, is Emeritus Dean and Emeritus Professor of Medicine. Dr. Sodeman was named the Magee Professor in 1957 and Dean in 1958, a post he held until 1967. He is a past President of both the American College of Cardiology and the American College of Physicians. Dr. Edward L. Bauer '14, right, Emeritus Professor of Pediatrics, was named Chairman in 1930, a post he held till retirement in 1957. An author of several books he is best known for his "Doctors Made in America."*

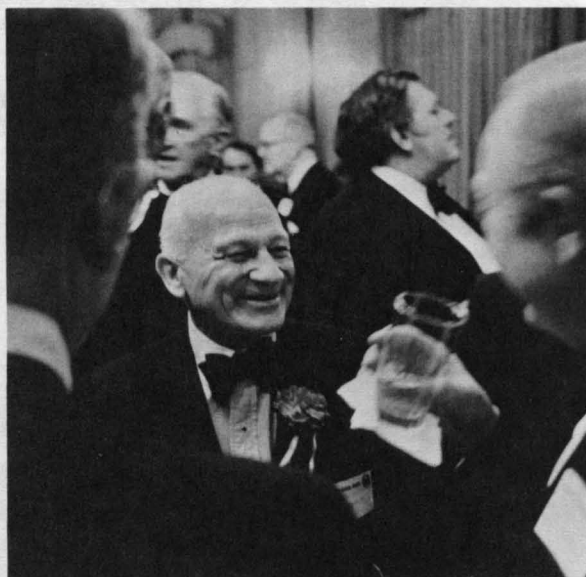






*At left Dr. John B. Montgomery '26, Emeritus Professor of Obstetrics and Gynecology. He spent his entire career at Jefferson beginning with his year as an intern in 1926. He holds honorary degrees both from Jefferson and Juniata College. Foreground is Dr. William W. L. Glenn '38, Professor of Surgery at Yale Medical School and Chief of Cardiothoracic Surgery at Grace New Haven Hospital. Dr. Glenn received the Achievement Award in 1973.*

*Dr. Baldwin L. Keyes '17, Emeritus Professor of Psychiatry and 1971 recipient of the Achievement Award. Dr. Keyes was appointed the first Professor and Chairman of Psychiatry at Jefferson in 1941, a post he held until 1958.*



*Dr. Henry B. Decker '20 (above), Emeritus Professor of Dermatology. He was appointed Chairman in 1950 and served until 1958.*

*At right, Dr. Abraham Cantarow '24, Emeritus Professor of Biochemistry. He was appointed in 1945 and became emeritus in 1966. Presently he is Research Planning Officer, Office of the Director, National Cancer Institute in Bethesda.*



# jefferson scene

## family medicine residency

Dr. Paul C. Brucker, Chairman of Jefferson's Department of Family Medicine, announced the beginning of a new three-year residency program in family medicine at Jefferson. The American Medical Association's Council on Graduate Education has given the project official approval. Dr. Brucker, who stresses that family medicine requires substantial competence in many specialties, will detail the new program in the summer issue of the Alumni Bulletin.

## ophthalmologist-in-chief

Dr. Thomas D. Duane, Chairman of the Department of Ophthalmology and Chief of Service at Thomas Jefferson University, has been named Ophthalmologist-in-Chief at Wills Eye Hospital and Research Institute. He will continue in his Jefferson positions, however.

Dr. Duane gained national attention for his research leading to an understanding of the cause of blackouts among pilots during the Korean War. He is the author of a book on ophthalmologic research, and is currently investigating the physiology of the retina, retinal circulation and the biophysics of ophthalmology.

The physician received his B.S. degree from Harvard University and his M.D. from Northwestern University. Prior to his arrival at Jefferson he was a Research Associate with the University of Pennsylvania's Medical

School. In addition to his department chairmanship at Jefferson, he served for three years as President of the Medical Staff and is currently Chairman of the Curriculum Committee (see page 2).

## grant

The National Deafness Research Foundation has awarded Jefferson a \$6500 one-year grant to continue the exploration of laser beam surgery as a remedy for otosclerosis, a condition whereby excessive bone growth interferes with the transmission of sound.

The experimental technique under study at Jefferson uses a bright pinpoint of blue laser light, directed through a microscope for only a fraction of a second to break through the bone barrier. According to the principal investigator for the study, Dr. Chester R. Wilpizeski, successful trials with animals indicate that the new method could allow access to the deepest areas of the inner ear. Dr. Wilpizeski is an Associate Professor of Otolaryngology at Jefferson.

## faculty changes

Dr. Ernest M. Brown, Jr., promoted to Clinical Professor of Medicine  
Dr. Lawrence J. McStravog '45 promoted to Clinical Professor of Otolaryngology

Dr. Otto Pollak appointed Visiting Professor of Psychiatry and Human Behavior

Dr. Harry L. Smith 'GS57 promoted to Professor of Microbiology

Dr. Nathan M. Smukler '47 promoted to Professor of Medicine.

## WHO appointment

Dr. Joseph S. Gonnella, Associate Dean and Director of Academic Programs at Jefferson, has been named a Consultant in Medical Education to the World Health Organization (WHO). During March and April he assisted the Director of the Organization's Regional Teacher Training Center in the planning and implementation of programs for faculties of medical schools in

Australia, the Philippines, Korea, Japan and others. Workshops were held in the topics of curriculum, teaching methods and evaluation. The assignment took Dr. Gonnella to Sidney and Manila.

## 1961 society

A new group has been organized at Jefferson called the 1961 Society. It was formed by a group of women medical students who felt that communication between women at various stages of their medical careers would be beneficial to all concerned. The name "1961" was chosen to commemorate the year that women were first admitted to Jefferson's Medical School.

The group is open to women from all the health professions, and to interested men. Its primary goal is to provide a forum for common concerns, ideas and experiences of women in medicine, and to form a group with potential for future action. It hopes to give women in different branches of medicine a chance to meet and know each other and to build a closer, more understanding relationship between them. Doctors would benefit from knowing what nurses and technicians think and feel, and vice-versa. Better patient care should result as the medical team becomes more integrated. A plan for increasing enrollment of Pennsylvania women at Jefferson is also under consideration.

Meetings of the 1961 Society are held bimonthly evenings with a speaker once a month. The group's sponsor is Dr. Mary-Louise Soentgen, a perinatologist at Jefferson. For more information, including the dates, times and places of meetings, contact the Society at Box 61, Jefferson Hall.

## sesquicentennials

Both Jefferson and Philadelphia's Franklin Institute celebrate their one hundred fiftieth birthdays in 1974, and in honor of their sesquicentennials the affiliated institutions jointly sponsored an anniversary dinner and lecture on April 3 at the Franklin



Institute. Speaker and guest of honor at the buffet supper was Dr. Joseph Kerwin, physician, captain USN, and NASA astronaut.

Dr. Kerwin received his M.D. degree from Northwestern University in 1957. He has been a member of the Navy Medical Corps since 1958 and has logged 2,700 hours as a Navy flight surgeon. Selected as an astronaut-scientist in 1965, Dr. Kerwin was science-pilot for Skylab-2, serving with astronauts Charles Conrad, Jr. and Paul J. Weitz. He is a Fellow of the Aerospace Medical Association and has been awarded the NASA Distinguished Service Medal, the Johnson Space Center Commendation Award and the Navy Distinguished Service Medal.

## president

Dr. George H. Strong, Associate Professor of Urology at Jefferson, has been elected President of Jefferson's Volunteer Faculty. Dr. Strong will serve a one-year term.

## black and blue ball

Kappa Beta Phi Fraternity, Jefferson's honorary social fraternity, announces that the Black and Blue Ball for 1974, the Sesquicentennial year, will be held at Jefferson Alumni Hall on May 11 at 9:00 P.M.

The Ball, one of several social functions during the Sesquicentennial year, is open to all members of the Jefferson family including alumni, faculty, staff and students.

Guest of Honor at this year's Ball will be Dr. Peter A. Herbut, President of Thomas Jefferson University.

Proceeds from the Ball are placed in Kappa Beta Phi's Student Loan Fund, which makes monies available to junior and senior students in amounts up to \$400 per year. The Fund is now valued at over \$5,000.

For further information or tickets (\$15 per couple, for alumni, faculty and staff; \$8 per couple for students and house staff) write Mr. Jim Plumb, 1000 Walnut St., Apt. 700, Philadelphia, Pa. 19107.

# alumni president

1974 Alumni President John J. Gartland 'S44, who assumed office at the Association's March 1 dinner and meeting at the Union League, sees his Sesquicentennial Presidency as a special opportunity.

"I think the next ten years are going to be the greatest decade in Jefferson's history. I think we are going to realize tremendous benefits from university status, because we have an administration that understands the possibilities for medical excellence introduced by the university concept. With the new programs envisioned in the Sesquicentennial campaign, we have an opportunity to expand both physically and philosophically. As Alumni President I want the Association to help broaden our perspectives so that we all realize the uniqueness of a truly meaningful medical university."

The new President sees the Alumni Association's role in part as that of a watchdog, "but our primary function is to support the University." He is sanguine about Jefferson's future, "because what we have now is very good. We've had problems, but they've been for the most part well-handled. The Alumni Trustee program, for instance, has given Jefferson a greater cohesiveness. People are talking to each other now where they didn't for a long time. The whole environment here has been influenced by the improved communications, with mechanisms for hearing new ideas implemented from the Trustee level on down."

Dr. Gartland's own perspective on Jefferson is the result of many years

of service with the institution and with the Alumni Association. At the Medical College he is the James Edwards Professor of Orthopaedic Surgery and Chairman of the Department. He is Chairman of the Affiliations Committee, a member of the By-laws and Sesquicentennial Committees and notes that he has been a member of both the full-time and part-time faculties.

An active member of the Alumni Association, Dr. Gartland had served as its Secretary and Vice-President prior to assuming the Presidency. A long-time member of the Executive Committee and Chairman of its Alumni Trustee Committee, he has also served as Class Agent for the Class of 'S44 for twenty years.

Dr. Gartland's positive feelings about Jefferson also stem from the very personal involvement he has had with the institution since childhood. "As a boy I was operated on in 'the pit' by Dr. Rugh, the first James Edwards Professor of Orthopaedic Surgery. Three Professors later I was named to the James Edwards chair, and I had the opportunity to repay Dr. Rugh by operating successfully on his widow."

In addition to his Jefferson responsibilities, Dr. Gartland is active in his specialty. A member of the American Orthopaedic Association and a Fellow of the American Academy of Orthopaedic Surgeons and the American College of Surgeons, he has many publications to his credit including a textbook, *Fundamentals of Orthopaedics*, whose second edition is scheduled for September, 1974. He has been a full member of the Society of Sigma Xi since 1954. Dr. Gartland's society memberships are more than token; he is particularly interested in his work with the Sub-Committee on Undergraduate Education for the American Academy of Orthopaedic Surgeons and with the Residency Review Committee for Orthopaedic Surgery. Dr. Gartland also serves as Associate Editor of *The Journal of Bone and Joint Surgery*.

Other elections reported on page 44.



*Dr. Gartland, the new Alumni President, at interview in Eakins lounge of Jefferson Alumni Hall. In background is the Gross Clinic.*

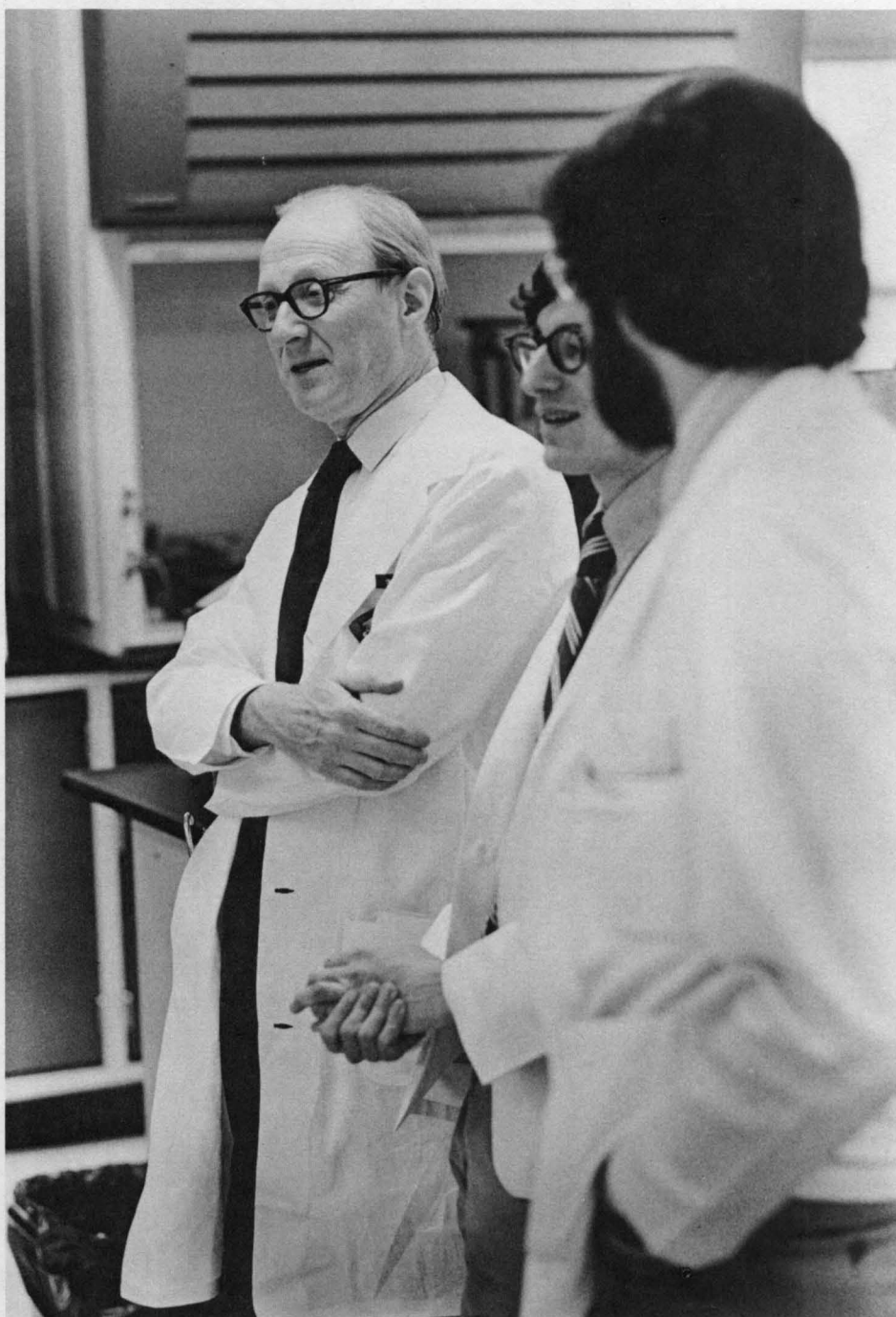


## profile

Despite Dr. Franz Goldstein's ('53) demanding schedule as Chief of the Department of Gastroenterology at Lankenau Hospital and Professor of Medicine at Jefferson, his son Richard wants to be a doctor. Richard's ambition obviously pleases Dr. Goldstein, but the physician is equally proud of his son's decision first to pursue a liberal arts education at Amherst College rather than specializing immediately and exclusively in science. "A background in the humanities and the social sciences is vital to the true physician. A good doctor has to be more than a technician."

Dr. Goldstein himself is the antithesis of the medical "mechanic." Charming and continental, he speaks knowingly and lovingly of fine food and good wine. Classical music, particularly chamber music and the opera, competes for his limited leisure time with other interests like gardening, sailing and history. Although he laughingly calls himself "a square" because he and his family spend many vacations at the New Jersey shore, his perfect manners and Old World manner belie that notion.

Born in Germany in 1922, Dr. Goldstein came to the United States in 1947. Although he had taken pre-medical studies at the University of Würzburg from 1945 to 1947, he came to America as a refugee, in no position to pursue his medical education. He got a job as a technician in Dr. John H. Gibbon, Jr.'s ('27) surgical research laboratory; with Dr.



*Dr. Goldstein*

Gibbon's help and encouragement he was accepted as a student in the Medical College two years later. Dr. Gibbon's faith in his protégé was not misplaced. Dr. Goldstein graduated first in the class of 1953.

The Jefferson tradition of personal education has been very much evident in Dr. Goldstein's experience. When he talks about his medical education it is in terms of the men

like John Gibbon and Dr. Harold L. Israel '34, who provided inspiration because their interaction with students on a human level gave greater meaning to relationships on the professional level. Professor of Industrial Medicine Dr. Heinrich Breiger had a special influence on Dr. Goldstein's education, as did Dr. Henry L. Bockus '17 who was his Chief during internship and residency

at the Graduate Hospital of the University of Pennsylvania. "He was unquestionably the greatest teacher I ever had, in this country or in Europe," Dr. Goldstein notes. "It was really because of him that I went into gastroenterology."

Dr. Goldstein's career as a gastroenterologist has consciously combined three related responsibilities: teaching, research and practice. He began teaching at Jefferson as an Instructor in Medicine in 1957, moving up through the academic ranks to his present full Professorship; the physician moved to Jefferson's affiliate, Lankenau Hospital, in 1970. As Chief of Lankenau's Department of Gastroenterology he teaches undergraduate medical students on rotation and on electives from Jefferson and of course house staff.

Dr. Goldstein has a very definite approach to teaching, and, judging by enrollment and response, the students find it a good one. "I like to teach critical thought, particularly to the undergraduates. With all the conflicting opinions and information we have to work with, medicine cannot be learned by brute memory alone. Certainly memorization of the basics is necessary and desirable, but beyond that a logical approach to problem-solving, constructive self-criticism and the self-discipline to keep medical education an ongoing process are invaluable to the good physician."

In general Dr. Goldstein teaches by precept and aims at informality. In the twelve-week block for juniors, for instance, he and his associate, Dr. Thornton, select the most important diseases and unfold a case for each one, going over X-rays and clinical findings with the students. A written hand-out provides more detailed information, and there are no lectures because "I just don't like lectures." The seniors and house staff are taught more informally. At the well-attended weekly gastroenterology conferences, students, house staff and physicians discuss patient problems. Participation in patient care is re-

quired from the junior level on up. "I'm not the first to remark on this," Dr. Goldstein smiles, "but teaching helps to keep me young. We all learn a great deal from our students and from the teaching process itself."

The respect Dr. Goldstein gets from his students is returned equally. "I have never had indifferent students, at Lankenau or at Jefferson. I think they respond to a teacher who is willing to teach, because they want to learn, especially clinical medicine."

Research and patient care are as enjoyable for Dr. Goldstein as teaching. He is more involved with private practice now than with research, although research once took precedence. Dr. Goldstein is a therapy-oriented physician despite what he sees as a tendency toward therapeutic nihilism among many medical men today. He feels a physiologic approach is often helpful in dealing with patients suffering from so-called functional bowel disturbances and the results speak for themselves.

"I enjoy my patients," says Dr. Goldstein. "And gastroenterology is a great field because most diseases are manageable, most patients can be helped." He finds clinical investigation a natural complement of clinical practice. "There is still a tremendous opportunity in clinical medicine for new observations to be made and for the application of basic knowledge at the bedside. This, as Dr. Bockus communicated to all of us, is part of the joy of medicine."

As a medical researcher Dr. Goldstein is somewhat unique: he *likes* to write. His more than ninety scientific publications, concerned with such topics as inflammatory bowel disease and the relationship of bacterial flora of the small intestine to the absorptive function, have been in no sense a chore for him. Working on his chapters in Dr. Bockus' classic work on gastroenterology was a particular pleasure. "Dr. Gibbon got me interested in writing. He, of course, was a poet, truly concerned with the beauty of language. He was even fastidious about his business letters.

When I wrote papers as his technician, Dr. Gibbon literally spent hours with me, going over the language in minute detail."

Somehow, Dr. Goldstein also finds time for active professional society memberships. He's involved with the Committee on Education and Training of the American Gastroenterological Association and with several committees of the American College of Physicians, helping, for example, to prepare the Medical Knowledge Self-Assessment Program. A member of the American College of Gastroenterology, he is also Secretary General of the Bockus Society, an international association of gastroenterologists formed when Dr. Bockus retired in 1958 to promote education and good will among practitioners of his specialty. Locally, Dr. Goldstein was Chairman of the Philadelphia Gastroenterologic Training Group in 1973 and is currently a member of the Scientific Advisory Committee of the Ileitis and Colitis Foundation. The physician is also active on hospital and university committees at Jefferson and at Lankenau. Among other responsibilities he serves as an elected representative of the Lankenau Staff to the Hospital's Executive Committee and Board of Trustees.

Jefferson has been important to Dr. Goldstein in other than medical matters. "I met my wife in the Jefferson doghouse," he laughs. "We were both working in research, my future wife in Dr. J. Earle Thomas' department." He and his wife live in Penn Valley, and in addition to their son Richard, they also have two daughters, both of whom are gymnastic enthusiasts.

Despite Dr. Goldstein's many professional responsibilities he consciously keeps a fairly regular schedule to allow for a normal family routine. "I've been blessed with a happy family life and professional satisfaction," Dr. Goldstein says. Having grown up in an atmosphere of fulfillment, it is little wonder that Richard finds the prospect of a medical career so appealing.



# Health Care for the Healthy

by

**Willard A. Krehl, M.D., Ph.D.**

The conception, implementation and continuing growth of the Health Maintenance Clinic represents a cherished and legendary position of significance for the Department of Community Health and Preventive Medicine, extending over the past twenty-five years. The utilization of the Health Maintenance Clinic as an educational opportunity for Jefferson medical students and an important health service for the community to which Jefferson relates, represent major concerns of the Department. The impetus for the development of the Health Maintenance Clinic dates back to the era of Dr. William Harvey Perkins, who came to Jefferson in 1941 to serve as its Dean and organizer of the new Department of Preventive Medicine.

Dr. Perkins had, from his missionary experience, recognized the overwhelming challenge of attempting to provide adequate quality medical care for "crisis" medical problems and therefore turned his attention and emphasis to the potential for the prevention of the premature occurrence of disease and to health maintenance. Subsequently, in 1948 he was instrumental in organizing, at the Fife-Hamill Memorial Health Center at Seventh and Delancey Streets in Philadelphia, a Health Maintenance

Clinic under the auspices of the Department of Preventive Medicine of Jefferson Medical College. "Persons presumed to be healthy were registered at the clinic for periodic physical examination and instruction in health habits and proper hygiene as well as advice on environmental, economic and personal problems relating to the early detection of health hazards or prodromes of disease." In the operation of the clinic, a comprehensive patient history and the details of the environmental circumstances in which the individual lived were obtained on the first visit to the clinic. This was followed routinely by a thorough physical examination, including a pelvic examination for women, a complete blood count, urinalysis, serology for syphilis, stool examination for parasites, and an X-ray of the chest. Special laboratory tests were also included as indicated. As far as practicable in those early days, home visits were made by Public Health Nurses accompanied by senior medical students of Jefferson Medical College. These home contacts permitted a personal appraisal of the relevant environmental factors which influenced the final disposition of cases. Dr. Bernard Blum, Professor of Public Health, was Director of the Fife-Hamill Memorial Health Center until 1954. The patient experience of the Health Maintenance Clinic between its origin in September of 1948 to February of 1953 covered 1,500 consecutive patients, and this was reported by Mackmull, Menduke and Cava in the Public Health Reports, Volume 70, pages 598 to 604 of June, 1965.

Dr. Gulden Mackmull continued

the active direction of the Clinic until July 31, 1955. Dr. J. Woodrow Savacool took over the direction of the Clinic on December 1, 1955 and was most ably assisted by Dr. W. Bernard Kinlaw. The clinic flourished under the leadership of these two able men which made the Fourth Year Clerkship in the Health Maintenance Clinic very attractive to medical students.

In 1959, the Fife-Hamill Health Center was closed and the Health Maintenance Clinic was transferred to the Jefferson Curtis Clinic and here has continued as an integral part of the Department of Preventive Medicine's instructional and health services program to this time. In 1964, private practice led Dr. Kinlaw to withdraw from the program and the next year Dr. Savacool gave up his participation. On July 1, 1965, Dr. Irwin L. Stoloff assumed the direct responsibility for the clinic operation and he has continued up to the present time.

In July 1966, the scope of the Health Maintenance Clinic was extended to include a program of "Health Hazards Appraisal and Comprehensive and Continuing Patient Care." This concept was proposed as a method of outlining a preventive medicine program in comprehensive health care which could be incorporated into a physician's practice. The principle is based upon the fact that every individual is faced with certain quantifiable health hazards as a member of a sex-age-race constituted group; and further, that these average risks may be adjusted to the individual if the clinician knows the patient's prognostic characteristics and the mortality experience of cohorts with similar prognostic characteristics. It is evident that this afforded the opportunity of utilizing vital health data and biostatistics, a major tool of preventive medicine, as a key component to quantify health hazards appraisal and health maintenance. This, in fact, was the birth of "Prognostic Medicine." The health appraisal concept is applicable to three types of "hazards" of premature death: those

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*Dr. Krehl received his appointment as Professor and Chairman of the Department of Community Health and Preventive Medicine at Jefferson on February 1, 1970. Prior to this he was Professor of Internal Medicine at the University of Iowa School of Medicine and Coordinator of the Iowa Regional Medical Program.*

of potential (asymptomatic) importance from a statistical basis; those of early (incipient) disease; and those of fully developed (overt) disease.

It is relevant to note that the early development of the Health Maintenance Clinic was primarily an educational endeavor, but as time passed it became increasingly evident that it served an extremely important health service role in a new and unique approach to total health care delivery. The emphasis was not on the sick population but on the healthy population and the identification in this group of those factors which were known to induce premature morbidity and mortality. This is far more comprehensive than a multi-phasic screening approach, in view of the fact that its emphasis is not only on the identification of problems, but through the appropriate application of risk reduction techniques to substantially improve the prognostic characteristics of the individual, i.e., reduce risk and provide a health advantage. In fact, it is important to emphasize now that the new *thrust* of the Health Maintenance Clinic will be increasingly directed toward efforts to reduce risks in a number of areas through the use of nutrition and diet counseling, exercise programming, habituation counseling (smoking, alcohol useage and drug abuse) and finally, behavioral and personal attitude analysis of the individual's concerns and responsibilities for his personal health. These approaches, as they relate to individual risk reduction and greater individual involvement in health care responsibility, indicate new and innovative avenues of operational involvement utilizing other components of the allied health team, particularly dietitian-nutritionists, behavioral scientists and rehabilitation workers. It is, of course, evident that the Health Maintenance evaluation program provides a unique opportunity for healthy people to enter the health care system, through referral to appropriate health services, for attention to the specific medical

problems that may be unearthed during the health appraisal.

In the early years, and in fact up until approximately three years ago, the patient load in the Health Maintenance Clinic ranged from two hundred to four hundred individuals per year. The major support for the clinic operation has come through the support of professional salaries in the Department of Community Health and Preventive Medicine by the Medical College in recognition of the role of the Health Maintenance Clinic in the educational program of Jefferson Medical College. In more recent years, a contract grant from the U. S. Public Health Service was utilized to support some of the operational phases of clinic activities with respect to nursing, secretarial, evaluative and patient instruction services, as well as a program of indoctrination for practicing physicians.

In the last three years, we have seen an increasing utilization of clinic services by more and more people. Three years ago, the patient population increased to slightly over six hundred, in 1971-72 the patient load rose to 1,125; and in 1972-73 the patient census was 1,026. With constraints on funding from the Federal Government and with a reduction of direct support of services provided by the Curtis Clinic itself, particularly of nursing and secretarial support, the operation of the Health Maintenance Clinic has increasingly depended upon fees generated from the individuals who attend the clinic for health maintenance evaluation. As costs of laboratory and associated services have progressively increased, it has been necessary to increase the fee charged the patient attending the Health Maintenance Clinic. Since these fees are not covered by third-party payors and are the direct responsibility of the clinic patient, it is evident that we are rapidly approaching the point where our fee level might price our clinic clientele "out of the picture." It therefore becomes increasingly important to

evaluate all clinic costs as critically as possible to utilize those services that are available at the best competitive advantages.

We are now in a transition period during which time we must prepare to move the health maintenance program from its present position in the Curtis Clinic to a new operational environment and a new kind of fiscal responsibility in quarters to be made available in the Edison Building. Every effort must be made to continue this as an educational and community health service commensurate with sound fiscal responsibility. The Department of Community Health and Preventive Medicine looks forward to working with the administration in making this transition possible.

As one looks at the overall health scene in the United States and the mechanisms for developing and delivering quality health services, it is increasingly evident that most segments of the health care industry, the government and the consumer want to have a well-defined program of preventive medicine. Again, we emphasize that we have a long heritage of experience in providing such preventive health services and this experience should merge successfully into preventive programs of the future. Thomas Jefferson University and the Jefferson Medical College may well look with pride at the creative genius of Dr. William Harvey Perkins who, just twenty-five years ago, initiated the program of health maintenance here at Jefferson Medical College which has continued to grow and flourish. The Department of Community Health and Preventive Medicine is appreciative of the support of the Curriculum Committee, its faculty and personnel, and the administration for the continued support of the Health Maintenance Clinic. While there is little doubt that this was an idea that was born before its time, it is now an idea with an established experience which will permit it to flourish in the present and in the future.



## class notes

### 1924

Members of the class of 1924 and their wives are cordially invited to a fiftieth reunion dinner on Wednesday, June 5 at the Barclay Hotel. Chairman Dr. Henry A. Brodtkin hopes all will make a special effort to be on hand for this important anniversary.

**Dr. Charles L. S. Brennan**, 14 S. Broadway, Gloucester City, N.J., is still working about two full days a week "just to keep my circulation going."

**Dr. Thomas E. J. Larkin**, 3333 N.E. 34 St., Fort Lauderdale, Fl., passed his Florida state boards in 1971 and is doing part-time work in Broward County Clinics.

**Dr. Lawrence Shinabery**, 212 Three Rivers, North, Fort Wayne, In., retired from the practice of medicine in 1967 and from all business activities as of December 1973. He and his wife plan to winter in Florida and summer in Indiana.

### 1925

**Dr. Carl M. Hadley**, 3120 Parkside Dr., San Bernardino, Ca., intends to retire at the end of this year.

**Dr. Sigmond J. Shapiro**, 3893 E. Market St., Warren, Oh., is semi-retired. His son **Richard '64** is now doing ophthalmology in Warren. He has another son who is a first year resident in ophthalmology at Jefferson. "I hope to be down for my forty-ninth and fiftieth."

**Dr. Chester P. Swett**, R.F.D. #7, 1525 Woodland Heights La., Lancaster, Oh., retired October 1, 1973.

### 1926

**Dr. J. Wallace Cleland**, 327 Wendy La., Waverly, Oh., writes that he has retired. He and his wife enjoy living in Bristol Village there and are in good health. He helps run a children's health clinic, and assists with school immunization programs, Head Start, etc.

**Dr. George C. Griffith**, P.O. Box 672, LaCanada, Ca., is Chairman of the Sesquicentennial campaign in California and Arizona.

**Dr. Edmund T. Lentz**, 19 Warwick St., Portsmouth, Va., is employed by the Virginia Plasma Corporation of Norfolk.

### 1928

**Dr. Clarence A. Bowersox**, 106 S. Columbia St., Woodbury, N.J., enjoyed

the Alumni trip to Yugoslavia in April.

**Dr. Lundie C. Ogburn**, 3230 Pensby, Winston-Salem, N.C., writes that for the past five years he has been in forty-nine states, trailering more than 10,000 miles per year. He expects to stay home this year, however, because of the uncertain fuel situation.

**Dr. Jack A. Rudolph**, 10275 Collins, Apt. 531, Bal Harbour, Fl., writes that Pyramid Publications published his book, *Allergies: What They Are and What To Do About them*, in paperback in June, 1973.

### 1929

Members of the class of 1929 will celebrate their forty-fifth reunion on June 5. Dr. Alfred E. Troncelliti is the chairman. One event that day will be an afternoon function at the home of Dr.

### 1923

## class notes

Patrick Pasquariello. A dinner at the Warwick is scheduled that evening.

**Dr. Karl W. Hahn**, 521 Linden St., Bethlehem, Pa., writes that he does not expect that his health will permit him to attend his forty-fifth reunion.

**Dr. Joseph C. Hudson**, 11608 Balboa Dr., Sun City, Az., has retired there. He enjoys bicycling, swimming and working as camp doctor for the Boy Scouts in the summer.

**Dr. Carl L. Minier**, South Rd., R.D. 1, Mendham, N.J., has retired from hospital pathology after forty years. His son **Edward '56** is a general practitioner in Hackettstown, New Jersey.

### 1932

**Dr. Samuel R. Brandwan**, 804 Rose Bldg., Cleveland, Oh., is still practicing ophthalmology there.



*Dr. Ernest L. Noone displays the Centenarian Award of the Pennsylvania Medical Society at the one hundredth birthday party for his mother, Mrs. Ernest W. Sipple on February 2, in Elverson, Pennsylvania. On the right is Mrs. Noone. The portrait is of Dr. William H. Longsdorf, Jefferson class of 1865, father of Mrs. Sipple and grandfather of Dr. Noone. The flowers were presented to the honoree by Thomas Jefferson University and the Alumni Association of Jefferson Medical College.*

## 1934

**Dr. C. Wilmer Wirts** is acting as chairman for the fortieth reunion of the class of 1934 on June 5. He is planning a dinner at the Barclay Hotel that evening and hopes all classmates will be on hand.

## 1935

**Dr. George B. Craddock**, 620 Court St., Lynchburg, Va., is still in the active private practice of internal medicine in Lynchburg. He is currently President of the Virginia State Board of Medicine, of which he has been a member since 1963.

**Dr. R. Marvel Keagy**, 225 Logan Blvd., Altoona, Pa., is well and practicing pediatrics in Altoona. His partner is **Rodney L. Sponsler '62**.

## 1936

**Dr. Gabriel E. DeCicco**, 4501 Market St., Youngstown, Oh., has been elected to Who's Who in the Midwest.

**Dr. Peter Lancione**, 3609 Belmont St., Bellaire, Oh., is a member of the Ohio State Medical Board and is a past President. He is also a member of the Governor's Task Force on Health.

## 1937

**Dr. Milton H. Gordon**, 29 North Dr., Haddonfield, N.J., has been in Israel, where he volunteered his services at the start of the Yom Kippur War to work at the Kaplan Hospital in Rehovot. Dr. Gordon has practiced internal medicine since 1938. He is Senior Staff Member of Cooper Hospital and Staff President of Camden County General Hospital. He is a past Chairman of the Physicians Division of Allied Jewish Appeal.

Dr. Gordon also went to Israel in 1967 at the outbreak of the Six-Day War, working in Hadassah Hospital. Dr. Gordon and his wife have three children, one of whom lives in Israel.

## 1938

**Dr. J. Woodrow Savacool**, 146 W. Tulpehocken St., Philadelphia, has been appointed Director of the Student/Employee Health Service at Jefferson. Dr. Savacool has been with Jefferson since 1942 and holds the rank of Clinical Associate Professor of Medicine.

## 1939

The class of '39 will celebrate its thirty-fifth reunion with a dinner at the

Bellevue Stratford Hotel on Wednesday, June 5. Dr. John H. Hodges, reunion chairman, reports that special guests that evening will be Dr. and Mrs. Hobart Reimann, Dr. and Mrs. David M. Davis and Dr. Bernard Alpers.

**Dr. Nicholas E. Patrick**, 349 Toftree's Ave., State College, Pa., writes that he has started his "second career" as the emergency room physician for Centre Community Hospital in State College.

## 1941

**Dr. James A. Collins**, Box 22, Riverside, Pa., was reappointed Chairman of the P.M.S. Council on Education and Science for 1973-74. He was also reelected President of the Pennsylvania Continuing Medical Education Institute for this period.

Dr. Collins is Director of the Department of Medicine at Geisinger Medical Center in Danville.

**Dr. Arthur F. Hoffman**, 3619 Harris Rd., Ft. Wayne, In., writes that his son, Gregory, is a freshman at Jefferson. He is President of the Anthony Wayne Area Council Boy Scouts of America.

**Dr. John Y. Templeton, III**, 130 S. 9th Street, Philadelphia, was inaugurated as President of the Philadelphia County Medical Society at a dinner and meeting of the Union League of Philadelphia on January 16, 1974. Dr. Templeton, whose term will run for one year, is Professor of Surgery at Jefferson and serves as a Vice-President of the Alumni Association.

## 1942

**Dr. Edward M. McNicholas**, 932 Netherwood Dr., Norristown, Pa., has given up the practice of anesthesiology. He is now working for Merck, Sharp & Dohme in West Point, Pennsylvania. His daughter, **Kathleen**, graduated from Jefferson in 1973 and is a surgical resident at Columbia Presbyterian Hospital in New York.

**Dr. William G. Ridgway**, 115 N. 9th St., Akron, Pa., has been elected President of the Lancaster City and County Medical Society. A Diplomate and Charter Fellow of the American Academy of Family Practice, Dr. Ridgway has practiced in Akron since 1946. He is a Clinical Lecturer at Hershey Medical School and active in his community. Dr. Ridgway and his wife, Emily, have a son and a daughter.

## 1943

**Dr. Samuel S. Faris, II**, 239 N. Easton Rd., Glenside, Pa., has been installed as President of the Montgomery County Medical Society. A member of the Society since 1947, Dr. Faris has served on its committee on occupational health and will edit the Society's publication, *The Medical Bulletin*.

**Dr. Walter M. Uhler**, Pine Creek Rd., Chester Springs, Pa., has been appointed Medical Director of the Elwyn Institute. Previous to this position, Dr. Uhler served as the Medical Director of the Devereaux Schools.

## 1944J

**Dr. Burton L. Wellenbach** is chairman for the thirtieth reunion for the class of '44. His plans include a dinner on June 5 at the Barclay and a stag luncheon the following afternoon in the Faculty Club at Jefferson Alumni Hall.

**Dr. Stephen W. Bartoshesky**, 830 Spruce St., Wilmington, De., writes that his son graduated from Cornell Medical School and specialized in pediatrics at St. Louis Children's Hospital. He is now at Harvard School of Public Health.

## 1944S

A dinner dance at Cherry Hill Inn is scheduled for members of the class of '44S on Wednesday evening, June 5. Dr. Robert G. Salasin is chairman of the class' thirtieth reunion.

**Dr. William S. Rothermel**, 3750 Fulton Dr., N.W., Canton, Oh., writes that his son is taking a surgical internship at St. Lukes-Presbyterian Hospital in Chicago. "I am working slightly more than half time and am President of the Faultman Hospital Medical Staff."

## 1945

**Dr. Raymond C. Grandon**, 131 State St., Harrisburg, Pa., has been Secretary of the Pennsylvania Medical Society House of Delegates for three years and has been elected to serve as Trustee and Councilor of the Fifth District. He is President-elect of the Pennsylvania Society of Internal Medicine and a member of the State Board of Medical Education and Licensure. Dr. Grandon continues to serve as a Delegate to the American Medical Association and the American Society of Internal Medicine.



## Training on a One to One Relationship



*Dr. Madara in his Salem office with medical student Norbert Scharff.*

A new course at Jefferson Medical College, Philadelphia, entitled "Field Experience in Family Medicine" opened the doors last summer to a new concept of student-teacher relationships for Dr. John S. Madara '45 of Salem, and a third year medical student.

Norbert D. Scharff, twenty-four, of Haddonfield worked with Dr. Madara at his office on Market Street. He examined patients, conferred on diagnoses, attended clinics and even made hospital rounds with the local doctor.

The summer course gave Scharff his first opportunity to meet patients in an office setting. Previously he had only seen between ten to twelve patients on a one to one basis during the spring semester at Jefferson Hospital.

As a general practitioner, Dr. Madara had not had much opportunity to participate in a teaching role. The field practice gave him the opportunity to instruct Scharff in the latest family practice methods.

"He's driven me back to my medical books," Dr. Madara exclaimed and added that he had been doing a little learning as well as teaching with Scharff.

Dr. Madara summed up the summer's experience with the new course as "probably one of the most exciting things that's happened in my twenty-five years of medicine."

For Scharff, who is not yet sure in what area of medicine his interest lies,

the experience gave him a chance to see what family medicine is all about.

"What I like about family medicine is that you get to play detective all the time," Scharff confided in an interview.

He explained that the patients know how they feel, leaving the doctor to look for the signs and match them up with the sickness.

Scharff said he decided to become a doctor because "I like to meet people and I'd like to stay in the sciences."

He said he has always enjoyed the sciences more than the arts and loves talking to people.

"I get satisfaction out of helping people," Scharff said.

Scharff had to devote a tremendous amount of time to the summer course. He was in Salem and ready to start hospital rounds with Dr. Madara by 8:30 a.m. Hospital activities consumed the remainder of the morning hours.

The duo then had office hours from 1:30 to 5:30 or 6 p.m. Scharff also participated in a baby clinic and even made a few house calls (Dr. Madara noted that some general practitioners really do still make house calls) and a jail call.

"You usually get a couple of unusual things a day," Scharff commented when asked what was the most interesting case he had seen.

Each case he saw in Salem, Scharff said, reinforced what he had learned

from his medical textbooks. He was able to examine a patient with scleroderma, where the skin hardens, diabetes insipidus, where the patient suffers from a tremendous thirst and voids an excessive amount of urine; chronic myelocytic leukemia; congestive heart failure; trichuriasis, an intestinal worm; pneumonia; muscle tumor of the gall bladder; and pernicious anemia.

One patient came to the local hospital after her lung collapsed from an acupuncture treatment in Philadelphia.

Dr. Madara noted the sparkle in the medical student's eyes when he first examined a newborn baby, saw a circumcision and felt a liver.

Scharff said his professors at medical school and other students would tell him how an enlarged liver felt. He was beginning to feel he'd missed something when he finally got the opportunity. "I couldn't believe it was right there," he exclaimed.

"He has a good approach to the patients," Dr. Madara said.

Dr. Madara usually introduced Scharff to the patient then allowed him to do the complete physical. The two then conferred on what to look for, what questions to ask the patient and what form of treatment to prescribe. Many times Dr. Madara had Scharff examine the patient without looking at the medical history. Then the two compared notes.

"It surprises me how well the patients

accepted him." Dr. Madara said.

Scharff got a summer full of medical experience from other local doctors also. Since Dr. Madara is Chief of Staff at Salem County Memorial Hospital and knows most of the area doctors, everyone was aware of the medical student's presence in the county. No one hesitated to call Scharff when he had an interesting case. Dr. Madara said the idea of having a medical student around the local hospital was something new and exciting to the doctors.

They were all eager for him to be in on their cases," he said.

Medical school and the professional life of a doctor is hardest on the wife, both Dr. Madara and Scharff agree. Scharff said he has given his fiancée, a medical technologist at Jefferson, ample warning of the intensive hours of study he will have to put in when they are married.

The summer practice kindled a spark in Dr. Madara as well as Scharff. The two spent hours conferring on the practical and theoretical side of family medicine.

Dr. Madara sees the new course as a way of tying together medical theory with the practical side of medicine. He is impressed with Scharff's knowledge and said the student knows more now than he knew after his second year of medical school, partially due to the tremendous advances in technology.

The first two years of medical school kept Scharff devoted to the texts of such subjects as anatomy, physiology, pathology, pharmacology and behavioral science.

In the fall of 1972 he took a six-week course in psychiatry, twelve weeks in surgery, six weeks of obstetrics and gynecology, and six weeks of pediatrics. During the summer he took an elective in immunology and allergy.

Dr. Madara is excited about more than the summer course. The course is offered in the Department of Family Medicine at Jefferson. This is the first time there has been such a Department, the Doctor said.

"When I first went into practice the people said 'he's just a G.P.'"

The general practitioner is now becoming a specialized field which requires a board examination for doctors desiring to enter that field.

The family doctor, recently thought to be a vanishing race, may just be coming into its own. What better way to familiarize medical students with family medicine than to have them work with a general practitioner?

Working together to learn the latest methods of family medicine has been an experience neither Scharff nor Dr. Madara will forget.

**Dr. Edward H. McGehee**, 319 E. Gravers Ln., Philadelphia, was named Professor of Family Medicine at Jefferson in early spring. Prior to his full time appointment Dr. McGehee had a practice of internal medicine in Chestnut Hill. He also is serving as Secretary Pro Tem of the College of Physicians of Philadelphia.

## 1946

**Dr. Thomas M. Wiley, Jr.**, 1203 Shadow La., Fort Myers, Fl., has been promoted to Clinical Assistant Professor of Pediatrics at the University of Florida.

## 1947

**Dr. Charles J. Rodgers**, 1434 Keller Ave., Williamsport, Pa., was President of the Lycoming County Medical Society in 1973.

**Dr. Leonell C. Strong, Jr.**, 235 Highland Ave., Norton, Va., was honored as Citizen of the Year in Wise County, Virginia. He is a past President of the Wise County Medical Society, Wise County Cancer Society and the Wise County Shrine Club. He is a general practitioner who "still makes house calls for the aged and the poor." He and his wife, Jeanne, have three children.

## 1948

**Dr. James B. Loftus**, 2 Brentwood Dr., Suffern, N.Y., writes that he enjoyed his twenty-fifth reunion at Jefferson. He has been reappointed Director of Obstetrics and Gynecology at Good Samaritan Hospital in Suffern.

## 1949

Traditionally the twenty-fifth reunion class is the biggest of the ten reunions. During 1974, the Sesquicentennial year of the founding of Jefferson Medical College, the class of '49 will celebrate. Reunion chairmen, Harold Rovner and Martin Lindell, are planning a dinner dance at Jefferson Alumni Hall on June 5. Plan to be on hand.

## 1950

**Dr. Donald P. Franks**, 216 Plumas Dr., Oroville, Ca., writes that he has left Los Angeles after twenty years. He is practicing anesthesiology in a small town in Northern California and learning to be a rancher and an olive grower. His wife, Marilyn, and four sons are all "thriving."

**Dr. Marvin Goldstein**, R.D. #2, Pine Ridge Rd., Poughkeepsie, N.Y., has been named Director of the Department of Internal Medicine at Vassar Hospital in New York. He has been practicing in Poughkeepsie since 1958.

## 1952

**Dr. Gonzalo E. Aponte**, Chairman of the Department and Professor of Pathology at Jefferson, is on the editorial board of the *Annals of Clinical and Laboratory Science*.

## 1953

**Dr. Willard S. Krabill**, 120 Carter Rd., Goshen, In., graduated in June, 1973 from the School of Public Health at the University of California in Berkeley with a Masters in Public Health. He has now returned to his group practice in Goshen, and he is also College Physician at Goshen College.

**Dr. George L. Sexton, Jr.**, 1529 Reading Blvd., Wyomissing, Pa., has been appointed Chairman of the Section of Gynecology at the Reading Hospital.

## 1954

The twentieth reunion for the class of '54 will be a dinner dance at Jefferson Alumni Hall on Wednesday, June 5. Dr. Edward M. Podgorski is the chairman.

**Dr. Charles H. Greenbaum**, 8220 Castor Ave., Philadelphia, is Vice-President of the Northern Branch of the Philadelphia County Medical Society and Secretary-Treasurer of the Pennsylvania Academy of Dermatology.

## 1955

**Dr. Robert E. Berry**, 3593 Peakwood Dr., Roanoke, Va., writes "A big thank you to Jeff for remembering Jeff alum **John Martin 'J44** with a Jeff party in Norfolk." Dr. Martin presently is serving as President of the Medical Society of Virginia. Dr. Berry has been reelected Chief of Surgery at Roanoke Memorial Hospital.

**Dr. Thomas W. Georges, Jr.**, Associate Vice-President of Temple University Health Sciences Center in Philadelphia, has been elected Chairman of the Executive Board of the American Public Health Association. A former State Secretary of Public Welfare and Acting State Secretary of Health, Dr. Georges came to Temple in 1970. After earning a Master's degree in public health from Yale University, Dr. Georges was the



first physician to head the newly formed Pennsylvania Department of Public Welfare in 1958.

## 1956

**Dr. Bernard Berne**, 250 Westmoreland Dr., Wilmette, Ill., is both a Diplomate and a Fellow of the American Academy of Family Physicians.

**Dr. J. Harold Housman**, 312 Dartmouth Ave., Swarthmore, Pa., is in the second year of an ophthalmology residency at Jefferson.

**Dr. Anthony F. Merlino**, 2 Countryside Dr., N. Providence, R.I., President-elect of the St. Joseph's Hospital Medical Staff, has been appointed to the Hospital's Board of Trustees.

## 1957

**Dr. Ronald M. Match**, 7 Whitney Cle., Glen Cove, N.Y., presented "Common Errors in the Management of Wrist Lacerations" at the meeting of the American Association for the Surgery of Trauma in Chicago.

**Dr. Nicholas Spock**, 300 N. Shamokin, St., Shamokin, Pa., is a Charter Member and Diplomate of the A.A.F.P., and is in his second term as President of the Northumberland County Medical Society.

## 1958

**Dr. Donald M. Dill**, 1317A Ynez Pl., Coronado, Ca., has been elected both a Fellow and a Diplomate in the American Academy of Family Practice.

**Dr. William McMicken**, 139 Meadowbrook Dr., Huntingdon Valley, Pa., will marry Anita Montone on July 6, 1974. Ms. Montone teaches at Archbishop Carroll High School in Radnor. Dr. McMicken practices internal medicine in Philadelphia.

**Dr. Francis K. Moll**, 130 W. Market St., Danville, Pa., has been appointed an Associate in the Department of Orthopaedics at the Geisinger Medical Center.

## 1959

Members of the class of '59 have heard from their reunion chairman, Larry Mellon, several times during the year. His plans for June 5 will be a dinner dance in the Faculty Club of Jefferson Alumni Hall. Reservations now are being received.

**Dr. Charles L. Brodhead, Jr.**, U.S.N. Hospital, Box 144, San Diego, Ca., will complete a cardio-thoracic surgery residency in July, 1974. He has been promoted to Captain in the U.S. Navy.

**Dr. Stuart B. Brown**, 7925 S.W. 135th St., Miami, Fl., is now an Associate Professor of Neurology at the University of Miami School of Medicine. He is also the Director of the Child Neurology Service at this Institution.

**Dr. Leonard F. Greenberg**, 1335 Tabor Rd., Philadelphia, is in the private practice of internal medicine and cardiology with two associates. He is Treasurer of the Medical Staff of Einstein Northern and is a Clinical Assistant Professor of Medicine at Temple University School of Medicine.

**Dr. Tom D. Halliday**, 409 Second St., Marietta, Oh., announces the birth of a daughter, Mary Elizabeth, in November of 1972. He also has two sons, John, age 6, and Tom, age 3.

## 1960

**Dr. Gerald P. Collins**, 400 E. 56th St., Apt. 23-0, New York, was married in October, 1973. He has been appointed Director of Laboratories at the Community Hospital of Brooklyn.

## 1961

**Dr. James S. Horewitz**, 5675 Chelton Dr., Oakland, Ca., is in the full time private practice of psychiatry in Berkeley, California. "It is interesting and stimulating."

**Dr. Harold L. McWilliams, Jr.**, Paoli Memorial Medical Bldg., Paoli, Pa.,

December 26, 1973

To the Editor:

The Fall 1973 Jefferson Alumni Bulletin is on the Atkinson's will-not-forget list. Fridays when I teach at Jeff my son Robert and I usually meet for lunch. We talk over things, general indeed, but usually medicine drifts into the conversation, frequently Jefferson in particular. His mother and I and he are grateful for the fine article written about him in that issue. However, coincidental though it may be, under the class of '48 was a write up on Bob Laning, now an Admiral in the U.S. Navy. With him I was a student at Jefferson, worked with him during summers, interned at Jeff with him and when he was at the U.S. Naval Hospital in Philadelphia before his marriage he lived with us. Our son Robert was named after him. His advancement to Admiral could not have happened to a more deserving individual. We called Bob and Alice in Japan to congratulate them. We learned they were soon to be in Hawaii and as providence would have it, Bob Atkinson, who was on a fellowship at the University of Hawaii, was just able to meet the Lanings, having dinner with them the day before he left for the mainland to start at Jefferson. A small world it is.

The notation about Len Bender '48 was also a probe into my memory. Eve and I were married in June 1948 and after a brief stay in New York we took a plane to Bermuda and on it were Len and his bride. We stayed at Harmony Hall, a beautiful spot where I know the Haults, Quinns and Wellenbachs have stayed at one time or another.

The next surprise was the article about Don Blatchley who was the mascot of the class of '48. Many of us were pleased to be brought up to date about his racing accomplishments. We first learned of his interest at our Greenbrier reunion about ten years ago.

Finally was the article on the Jefferson Class of '48 Reunion. I cannot close without a word about Norm Quinn. He always places himself in the background but to him belongs the lion's share of credit for making the class a factor in Jefferson's history. When we left like all "young turks" many had this gripe or another about the "Establishment." Quite a few were less than enchanted. Through his perseverance, he led the class to be a top contender in an extremely competitive group (the rest of Jefferson's classes). Without his long and persistent efforts the class of '48 would be just another class and probably not a very good one. His efforts in smoothing the inevitable bumps on the tour road of our reunion were greatly appreciated and added to the enjoyment of the travelers.

Again, we are very grateful as I'm certain many of our class are, for a memorable issue of the Bulletin.

John Atkinson, M.D. '48

writes that we listed him incorrectly in the Winter Alumni Bulletin as a general practitioner. In reality, Dr. McWilliams is a surgeon, a member of the Medical and Chirurgical Society of Maryland and certified by the American Board of Surgery and Thoracic Surgery. Our apologies.

## 1962

**Dr. Martin Feldman**, 11860 Wilshire, Los Angeles, passed his Boards in gastroenterology.

**Dr. Richard J. Hamburger**, 1100 W. Michigan St., Indianapolis, In., is the Director of the Dialysis Program at the Indiana University School of Medicine and VA Hospitals. Currently President of the North Central Dialysis and Transplantation Society, he is a Fellow of the American College of Physicians and has been certified in the subspecialty of nephrology.

## 1963

**Dr. Dale C. Brentlinger**, 6165 E. Fair Ave., Englewood, Co., is practicing internal medicine in a group of five physicians. He is also a Clinical Instructor of Medicine at the University of Colorado Medical School.

**Dr. Robert D. Deitz**, 10118 Chickadee La., Adelphi, Md., has been elected Chief of Cardiology at Prince George's General Hospital in Cheverly, Maryland.

**Dr. Thomas E. Klump**, 6726 Eberlein Ave., Klamath Falls, Or., writes "Cross-country ski touring and mountaineering occupy most of our free time. Life is great despite fuel shortage, Watergate, etc."

**Dr. Eugene D. Kotchick**, Braewood Rd., R.D. #2, Dalton, Pa., announces the birth of a son, Gregory Francis, on December 2, 1973. He now has four boys and a girl.

**Dr. Rolf W. Lemp**, 403 River Rd., Fair Haven, N.J., is a member of the faculty at Rutgers University and is Director of Family Practice at Monmouth Medical Center in Long Branch, New Jersey.

**Dr. Robert S. Levitt**, 967 Hoover Dr., New Brunswick, N.J., has been Board Certified and is a Fellow of the American College of Obstetricians and Gynecologists. He and his wife have two daughters and one son.

**Dr. Wilfred T. Morioka**, 1432 Sandal Ln., La Jolla, Ca., has been named a Captain in the U.S. Navy Medical Corps. He is now with the Otolaryngology De-

partment of Balboa Naval Hospital in San Diego, where he also is an Assistant Clinical Professor at the University of California in San Diego.

**Dr. Thomas S. Patricoski**, 12210 S. 86th Ave., Palos Park, Il., recently has been elected President of the Beverly Branch of the Illinois Academy of Family Practice. He announces the birth of his third daughter and eighth child, Eve, in July of 1973.

**Dr. Henry F. Smith**, 126 S. Mt. Blvd., Mountaintop, Pa., is in general practice in the Wilkes-Barre area.

**Dr. Rodger J. Winn**, 36 Pembroke Rd., Summit, N.J., left his full-time position with Memorial-Sloan-Kettering and is now in private practice in oncology in Northern New Jersey. "My patients desperately need a national health plan and I hope physicians will be a constructive rather than obstructive force."

## 1964

The tenth reunion for the class of '64 is scheduled for June 5 at the Bellevue Stratford. Robert Mackowiak, chairman, will be in touch with all classmates in May.

**Dr. George E. Fleming**, 811½ N. Queen St., Kinston, N.C., has been named Chief of the Department of Anesthesiology and the Department of Inhalation Therapy at Lenoir Memorial Hospital. Dr. Fleming previously was a commander in the Navy. He is a Diplomate of the American Board of Anesthesiologists and a Fellow of the American College of Anesthesiologists.

**Dr. William L. Milroth** has opened an office for general practice in McConnellsburg, Pennsylvania. He was in private practice in Point Pleasant, New Jersey, and prior to coming to McConnellsburg served as a physician in the emergency room of Allegheny General Hospital.

**Dr. Alvin D. Oscar**, 538 Sussex Rd., Wynnwood, Pa., is a Diplomate of the American Board of Otolaryngology. He is practicing in the Roxborough section of Philadelphia. He and his wife, Barbara, have four children.

**Dr. Carl M. Pinsky**, Memorial Sloan-Kettering Cancer Center, New York, was cited in *Time* magazine for his work in immunotherapy. He has injected BCG, a live-bacteria anti-tuberculosis vaccine, directly into the lesions of thirty-nine patients with malignant melanoma; in eight patients there was noticeable regression of at least some of the treated lesions; twelve others had regression in

all of the sores injected with the vaccine; and two patients have experienced complete regression of all lesions and have been completely cancer-free for one and two years respectively.

**Dr. John E. Riffle**, 1210 St. Clair St., Hagerstown, Md., was certified by the American Board of Ophthalmology in May of 1973.

## 1965

**Dr. Joseph Y. Dwoskin**, 53 Berwin Dr., Amherst, N.Y., writes that his fourth daughter, Debra Ellen, was born on May 6. A pediatric urologist at Buffalo Children's Hospital, he is a Fellow of the American Academy of Pediatrics (urology) and is Board certified in urology.

**Dr. Benjamin A. Halpren**, 3427 Thomas Dr., Palo Alto, Ca., has completed a nephrology fellowship at Stanford and is now in private practice in Fremont, California. He is also the Director of Hemodialysis at Washington Hospital in Fremont, the Assistant Director of Hemodialysis at Stanford Medical Center and an Instructor of Medicine at Stanford Medical School. He has two sons, Michael, 5, and Jonas, 4.

**Dr. Thomas J. Schneider**, 4212 Oak St., Palm Beach Gardens, Fl., was elected to membership in the American College of Physicians and to Fellowship in the American College of Gastroenterology. He is also a member of the Executive Committee of the Palm Beach County Medical Society. "Busy doing GI but still go fishing with the family."

**Dr. Harvey Slater**, 5037 Somerville St., Pittsburgh, Pa., was certified by the American Board of Surgery in October, 1973.

**Dr. Joseph W. Smiley**, 604 Argyle Cle., Wynnwood, Pa., is in the group practice of internal medicine and nephrology and is Director of the Hemodialysis Unit at Mercy Catholic Medical Center in Philadelphia. He and his wife, Annette, had their first child, Carolyn Rae, on July 12, 1973.

**Dr. Richard C. Wilson**, 4384 Clearview Cle., Allentown, Pa., has joined a group of three internists. He practices at the Sacred Heart Hospital in cardiology and at Allentown Hospital in internal medicine. Classmate **David G. Jones** lives about a half mile away.

## 1966

**Dr. Joseph B. Blood, Jr.**, 735 S. Main St., Athens, Pa., is a staff internist at the





Scott



Orlowitz



Cardeza

## These Buildings Have What In Common?

The common denominator here is that these buildings or the programs housed in these buildings resulted from the warm relationship three patients had with their physicians. Possibilities are limitless for increasing Jefferson's many faceted programs through the development of grateful patients contacts. These three vignettes help tell the story.

Mr. Samuel Parsons Scott suffered from an asthmatic/allergic condition for many years until he met an unidentified Jefferson professor on a train to Washington. The physician gave Scott some unrecorded advice which Scott credited with substantially relieving his symptoms and prolonging his life. In 1931 Scott offered JMC an endowment of \$500,000 in gratitude for the help he had chance to receive. Jefferson's award-winning Samuel Parsons Scott Library and Administration Building (left) was constructed from that fund. Even

after endowment monies were allocated for library construction, a balance of \$1.3 million remains in the fund today.

Orlowitz Residence Hall (center), campus housing for Jefferson students and house staff, began in 1913 with an emergency appendectomy at Jefferson Hospital. The appendectomy patient, Mr. Louis B. Orlowitz, was grateful for the operation's success, and in 1963 he donated \$250,000 to Jefferson; the money went toward construction of the twenty-story building. Dedicated in 1973, Orlowitz is located at 1000 Walnut Street.

Not all grateful Jefferson patients have donated money for capital construction. Mrs. Thomas D. Cardeza, a Jefferson patient who suffered from chronic leukemia, and her husband contributed to Jefferson a \$4 million endowment for hematologic research. Known as the Charlotte Drake Martinez Cardeza

Foundation, the endowment has grown to \$10 million. The Foundation is currently housed on Sansom Street opposite the Thompson Annex (right). Mr. Cardeza, who was elected to Jefferson's Board of Trustees in 1939, also established the Thomas Drake Martinez Research Professor of Medicine in 1941; the chair has been held by Dr. Allan J. Erslev since 1963.

The Department of Medicine had earlier received another grateful patient grant from Miss Anna J. Magee. In 1916 the Magee Chair of Medicine was endowed in honor of Jefferson Professor Dr. James C. Wilson, who had treated Miss Magee for many years. It is stipulated that the chair shall be occupied by the Chairman of the Department of Medicine, which position was held by Dr. Wilson at the time of the endowment. Professor Robert I. Wise is the current Magee Professor of Medicine.

Guthrie Clinic in Sayre, Pennsylvania. He is also a Senior Instructor at Hahnemann Medical School. "Classmate John Pacanowski is here in Pediatrics."

Dr. William R. Collini, 9 Stonehedge Terr., Sparta, N.J., has recently been appointed Clinical Instructor of Urology at the New Jersey College of Medicine.

Dr. Franklyn R. Cook, 713 Cortlandt Dr., Sacramento, Ca., is Board certified in Ob-Gyn. He became a partner of the Permanente Medical Group in Sacramento in July, 1973.

Dr. Steven A. Friedman, 216 Brentwood Rd., Havertown, Pa., has completed his pulmonary training at the Cornell Medical Center and is now in private practice for pulmonary diseases in suburban Philadelphia.

Dr. W. Royce Hodges III has joined the staff of Memorial Hospital in Cumberland, Maryland in the Department of Anesthesiology. A member of the American Society of Anesthesiologists and the International Anesthesia Research Society, Dr. Hodges served his residency at the University of California, San Francisco. He and his wife, Diana, live at 328 Sunset Dr. in LaVale.

Dr. Ira Lable, 6 Rolling La., Framingham, Ma., is in private practice in Boston. He is a Clinical Instructor in Psychiatry at Harvard Medical School and an Assistant in Psychiatry at Massachusetts General Hospital.

Dr. Arthur B. Lintgen, 1245 Highland Ave., Abington, Pa., is a Diplomate of the American Board of Internal Medicine and is practicing internal medicine at Abington Memorial Hospital.

Dr. Arthur J. Schatz, 1870 N.E. 207th St., N. Miami Beach, Fl., is practicing obstetrics and gynecology in Miami. "Have become reacquainted with many fellow Jefferson graduates also practicing in the area."

Dr. Stanley R. Shorb, 130th Station Hospital, Heidelberg, Germany, APO New York, 09102, will complete his army obligation this coming summer. He will begin a one-year Fellowship at the Retinal Diagnostic Center of the University of California at San Francisco.

Dr. Robert L. Tober, 47 Royal Crest Dr., North Andover, Ma., is in the private practice of otolaryngology in Lowell, Massachusetts, after completing his service with the U.S. Navy. He became Board certified while in the Navy.

**Dr. Mark H. Zeitlin**, 12401 S.W. 109th Ave., Miami, FL., works at South Miami Hospital with a group of six other anesthesiologists. He was certified last October by the American Board of Anesthesiology.

## 1967

**Dr. G. Thomas Balsbaugh**, 2310 Williams View Dr., Harrisburg, Pa., spent the past two years as an Assistant Professor of Radiology at the Hershey Medical Center. He has relocated to Harrisburg and is associated with the Tristan Radiologic Associates, based at Polyclinic Hospital.

**Dr. Stuart L. Brodsky**, 1116 Heartwood Dr., Cherry Hill, N.J., won second prize in the Philadelphia Urological Society Resident's contest with his essay on "Gross and Radiologic Anatomy of the Canine Kidney." Dr. Brodsky is a resident in urology at Jefferson.

**Dr. Richard J. Flynn**, 787 S. Main St., Athens, Pa., has been named an Associate in Neurology at the Guthrie Clinic and Robert Packer Hospital in Sayre, Pennsylvania. Previous to this position he was Chief of Neurology at Keesler Air Force Base in Biloxi, Mississippi, during which time he was also an Instructor in Neurology at Louisiana State University Medical School and a staff member at the New Orleans Charity Hospital.

**Dr. Joseph E. Franger**, 2201 N. Cleveland, Chicago, Ill., will move to Madison, Wisconsin in July, 1974 where he will begin a Fellowship in GI at the University there.

**Dr. Joel B. Jurnovoy**, 3630 Chimney Swift Dr., Huntingdon Valley, Pa., will begin the practice of dermatology in the Delaware County Medical Center in June, 1974.

**Dr. Michael B. Kodroff**, 920 Chumley St., Portsmouth, Va., will finish his tour of duty in the Navy in June and will become Assistant Professor of Radiology (Pediatric) at the Medical College of Virginia in Richmond.

**Dr. Noreen M. March**, 7043 Clinton Rd., Upper Darby, Pa., has been appointed to the medical staff of Riddle Memorial Hospital. She is also on the staff of Mercy Catholic Medical Center, Fitzgerald Mercy and Misericordia Divisions.

**Dr. Elliot J. Rayfield**, 1332 Taney Ave., Frederick, Md., will become an Assistant Professor of Medicine and Assistant Director of the Clinical Research Center at Mount Sinai School of Medicine of

the City University of New York as of July, 1974.

**Dr. David L. Sall**, 1209 Centennial Rd., Narberth, Pa., is in the private practice of psychiatry at 3 Penn Center, Philadelphia. He and his wife have one son, Jacob.

**Dr. Scott C. Stein**, 2645 N.E. 25th St., Lighthouse Point, Fl., has been elected a Diplomate of the American Board of Anesthesiology. In private practice in Fort Lauderdale and Pompano Beach, Dr. Stein is also a Fellow of the American College of Anesthesiologists.

**Dr. Jonathan L. Williams**, 2991 School House La., Philadelphia, is studying pediatric radiology at St. Christopher's Hospital for Children in Philadelphia.

**Dr. John V. Zeok**, Apt. 331 B, 301 W. Sylvania Ave., Neptune City, N.J., announces the birth of a daughter, Suzanne Victoria, on November 3, 1973. She is the first child born to him and his wife, the former Suzanne Springer '69.

**Dr. Jay F. Ziegenfuss, Jr.**, 3435 Hillside Dr., Huntingdon Valley, Pa., will be at Abington Memorial Hospital in medical oncology beginning July 1.

## 1968

**Dr. Joel M. Barish**, 240 W. Queen St., #3, Inglewood, Ca., is a Fellow in GI at Harbor General Hospital in Torrance, California, having finished his medicine residency at U.C.L.A. His wife, Carole, will finish her pediatric residency there this year. They have a son born May 13, 1973, and they plan to settle on the southern west coast.

**Dr. William H. Barnaby**, 152 Tapia Dr., San Francisco, is a resident in neurology at Stanford University Medical Center. He plans eventually to return to practice in the Philadelphia area.

**Dr. Paul R. Bosanac**, 9 Olde Benchmark Vlg., Royersford, Pa., is completing his second year in the Army at Valley Forge Army Hospital in Phoenixville, Pennsylvania. In July he will begin a Fellowship in nephrology at the University of Pennsylvania.

**Dr. Wayne H. Braverman**, 6418 New Castle Dr., Fayetteville, N.C., is the Chief of Psychiatry and Neurology at the Woman's Army Hospital, and is "looking forward to discharge and private practice in July."

**Dr. William J. Dennis**, 402 W. 10th Ave., Conshohocken, Pa., was recently discharged from active duty after two years as a Navy pediatrician. He is

currently taking a Fellowship in pediatric neurology and habilitation at St. Christopher's Hospital in Philadelphia.

**Dr. John D. Frost**, 1710 Brink Dr., Anchorage, Al., is practicing orthopaedics at Elmendorf U.S.A.F. Hospital in Alaska. "Plenty of magnificent scenery and tremendous hunting and fishing."

**Dr. Lawrence V. Hofmann**, Department of Pediatrics, University of Mississippi Medical Center, 2500 N. State St., Jackson, Ms., is on the faculty of the University of Mississippi and is involved in outreach work, particularly in the poverty-stricken Delta area. "I am enjoying my work and hope to be here for some time."

**Dr. Stephen R. Kozloff**, 3405 Latana Way, Beale AFB, Ca. will finish his two-year service with the Air Force in July, 1974. He and his family will then move to Greeley, Colorado, where he will begin the private practice of obstetrics and gynecology.

**Dr. Martina Mockaitis Martin**, 829 Coopertown Rd., Bryn Mawr, Pa., is in the private practice of rheumatology and internal medicine with the Bryn Mawr Medical Specialists Association. Her husband, John H. Martin is a rheumatologist at Temple. They have three children, ages 11 through 14.

**Dr. Joseph E. Palascak**, 169-32-6968 Maj. M.C. USA-H, Camp Zama, Japan, APO San Francisco 96343, announces the birth of his first child, Joseph Boyd, on November 27, 1973 in Tokyo.

**Dr. John H. Robinson**, 2539 Carriage Dr., Toledo, Oh., is the Senior Plastic Surgery Resident at the Medical College of Ohio at Toledo. He and his wife, Judy, have three children, Michael, 5, Jennifer, 3, and Gretchen, 1.

## 1969

The first reunion for the class of '69 is scheduled for Saturday, June 9 at the Faculty Club of Jefferson Alumni Hall. Walter Finnegan, Chairman, has heard from approximately one half of the class. Plan to be on hand.

**Dr. Louis B. Balizet**, 1951 E. 3080 South St., Salt Lake City, Ut., is an oncology Fellow at the University of Utah.

**Dr. Alan L. Baron**, 466 Myrtle St., Laguna Beach, Ca., was married to the former Jane Eichelberger in December, 1973. Dr. Baron practices medicine in La Mirada, California.



**Dr. Alan S. Bricklin**, 1140 Sea Gull La., Cherry Hill, N.J., is on the pathology staff of Cooper Hospital, having completed his residency at the Hospital of the University of Pennsylvania. He has been certified by the American Board of Pathology. Dr. Bricklin and his wife had a second child this spring.

**Dr. Kay E. Frank**, 3250 E. 49th St., #3, Cleveland, Oh., is an Instructor in Ophthalmology at Case Western Reserve School of Medicine.

**Dr. Carol Hersh Levine**, 2206 A Wheeler, Killeen, Tx., announces the birth of a son, David Adam, on December 11, 1973.

## 1970

**Dr. John W. Breckenridge**, 7937 Heather Rd., Elkins Park, Pa., is a resident in radiology at Temple University.

**Dr. Michael D. Ellis**, 2318 Valley Rd., Huntingdon Valley, Pa., announces the birth of his third child, Susan Elizabeth, born on August 1, 1973. He is completing his obstetrical residency at Abington Memorial Hospital and plans to practice in that area.

**Dr. Robert C. Kane**, Whitehall West, Apt. 203, 8315 N. Brook La., Bethesda, Md., has been certified by the American Board of Internal Medicine and is completing his second year of military duty as a Clinical Associate with the National Cancer Institute in Bethesda. He and his wife announce the birth of their first child, Elizabeth Jill, on December 7, 1973.

**Dr. Barry J. Make**, 3296 University Ave., Morgantown, W. Va., is a commissioned officer in the U.S. Public Health Service's National Institute of Occupational Safety and Health, stationed at the Appalachian Laboratory for Occupational Respiratory Diseases. He is also an Assistant Professor of Medicine at the West Virginia University School of Medicine.

**Dr. Harry S. Polsky**, 2991 School House La., Philadelphia, announces the birth of his second child, Robin Lisa, on November 14, 1973.

## 1971

**Dr. Delvyn C. Case, Jr.**, North Shore Hospital Apts., Bldg. 6, Apt. 5-0, Community Dr., Manhasset, N.Y., is a Senior Resident in Medicine at the Cornell University Cooperating Hospitals and is Assistant Chief Resident in Medicine at the North Shore

University Hospital. Beginning July 1 he will be a Fellow in Oncology at the Memorial Sloan-Kettering Cancer Center in New York.

## 1972

**Dr. Stephen P. Flynn**, 3210 N. Van Buren St., Wilmington, De., is completing his second year of a family practice residency at the Wilmington Medical Center.

**Dr. Michael R. Lewis**, 224 Mabel St., Johnstown, Pa., announces the birth of a son, Michael Scott, on September 13.

**Dr. Rosalie K. Marinari**, 149 Briar Ct., Marlton, N.J., was married in May, 1973 to David A. Akouka, but continues to use her maiden name professionally. She is now a dermatology resident at Hahnemann "and loving it."

**Dr. Cheryl M. Naulty**, 7858 Briardale Terr., Rockville, Md., writes that she is in her second year of a pediatrics residency at Children's Hospital in Washington, D.C. and will begin a Fellowship in neonatology next year at the same institution. Her husband, Steve '72, is a first year resident in anesthesiology at Bethesda Naval Hospital. He is also a lieutenant in the Navy.

**Dr. Marshall A. Salkin**, Salem Harbour, Gatehouse 216, Andalusia Pa., married Ellen Jones, R.N., on November 21, 1973. Mrs. Salkin is a 1973 graduate of Jefferson's School of Nursing.

**Dr. Richard P. Schwartz**, 1718 W. Flourney St., Chicago, Il., is in his first year of a medical residency at Presbyterian-St. Lukes Hospital.

**Dr. Robert E. Steward, Jr.**, R.D. #6, Danville, Pa., is a resident in general surgery at Geisinger Medical Center. He has two sons, Robert III and Dwight W.

## 1973

**Dr. Joanna M. Firth**, C-621 Cedarbrook Hill Apt., Wyncote, Pa., will complete a pediatric residency at Keesler AFB, Biloxi, Mississippi. Her husband graduated from Temple Dental School in January, 1974.

**Dr. Peter R. Hulick**, 29 Windflower, Dr., Newark, De., will attend an eight-week course in radiologic pathology at the Armed Forces Institute of Pathology in Washington, D.C. in May.

**Dr. Joseph F. Mambu**, 1929 N. Senate Ave., Apt. 52, Indianapolis, In., announces the birth of a daughter, Niccole Christine, on August 17, 1973.

# Obituary

### Francis F. Borzell, 1906

Died December 12, 1973 at the age of ninety-one. A physician/radiologist, Dr. Borzell retired in 1959 after nearly fifty years as a general practitioner in the Kensington-Frankford area of Philadelphia and as a radiologist on the staffs of several area hospitals. He had been President of the Pennsylvania State Medical Society, the Philadelphia County Medical Society and the Philadelphia Roentgen Ray Society, and a former Speaker of the House of Delegates of the AMA. He received the Philadelphia County Medical Society's Strittmater Award in 1945. He is survived by a daughter, a brother and a sister.

### Alfred D. LaFerté, 1910

Died November 11, 1973 at the age of eighty-seven. The retired physician is survived by his wife, Katrina.

### Simon H. Rosenthal, 1913

Died December 9, 1973. Dr. Rosenthal had been in the practice of urology with his son in Lynchburg, Virginia.

### Oscar R. Clovis, 1917

Died June 3, 1973.

### William T. Leach, 1918

Died December 28, 1973 at the age of seventy-six. Dr. Leach served as Chief Surgeon at Locust Mountain Hospital in Pennsylvania from 1940 to 1963 and had also been Assistant Chief Surgeon at Ashland Hospital. A Fellow of the American College of Surgeons and President of the Davis

Society at Jefferson, Dr. Leach was known as a fine sportsman and active community leader. He is survived by his wife Adele, a daughter and six grandchildren, one of whom, Adele, is the wife of Jefferson medical student Edward Engle '75.

**Earl F. Ryan, 1919**

Died October 1, 1973 at the age of eighty-two. The general practitioner is survived by a niece and a nephew.

**William S. Colgan, 1923**

Died January 7, 1974. The former Bridgeport, Pennsylvania radiologist is survived by his wife, Florence.

**Rodney L. Stedje, 1925**

Died October 14, 1973 at the age of eighty. He had been Chief of the Department of Obstetrics at the Robert Packer Hospital in Sayre, Pennsylvania until 1957 when he went into general practice. He is survived by his wife, two sons and two step-daughters.

**Dirk C. Bloemendaal, 1927**

Died December 1, 1973. He had retired from general practice in 1965. Dr. Bloemendaal is survived by six children, among them sons John W. '55 and Robert D. '58.

**Joseph L. Magrath, 1927**

Died January 17, 1974 at the age of seventy-seven. A general practitioner in Upper Darby, Pennsylvania, he was a member of the surgical staff at Delaware County Memorial Hospital. He retired from that post in 1969, but had continued his general practice. He is survived by his wife, Mary Jane, and two sons, Terrence B. and Joseph L., Jr., '56.

**Yasohichi Yoshida, 1927**

Died January 27, 1974 at the age of seventy-three. An obstetrician/gynecologist, Dr. Yoshida was on the staffs of St. Vincent's Hospital for Women and Children and several other Philadelphia area hospitals. He was also chief surgeon of obstetrics for the Police and Fire Departments. He

had a private practice in his specialty until 1972. Surviving are his wife, Marie, two sons and three daughters.

**Lawrence C. Johnson, 1929**

Died in 1973 at the age of eighty. Dr. Johnson had retired from his Salinas, California practice in 1961. He is survived by his wife, Stella, and a daughter.

**Frederick H. Kramer, 1930**

Died October 21, 1973. The retired physician was a resident of Cambridge, Maryland.

**John A. Murray, 1931**

Died January 29, 1974 at the age of sixty-eight. Dr. Murray had been on the staff of Miners Hospital in Cambria, Pennsylvania for forty years prior to his retirement in 1971. In 1973 a Dr. John Allen Murray Inter-Faith Chapel was dedicated at Miners Hospital. A member of the Board of Incorporators of the Hospital, he had served as Secretary-Treasurer of its staff for thirty-two years.

A Fellow of the American College of Surgeons, Dr. Murray had been active in local medical organizations and in his community. He had also served as a member of the Executive Committee of the Alumni Association. Dr. Murray is survived by his wife.

**William P. Kenworthy, Jr., 1934**

Died September 1, 1973 at the age of seventy-six. Dr. Kenworthy had practiced medicine in Atglen, Pennsylvania for thirty-seven years prior to his retirement. He was active in his community and until 1970 had served as the examining physician of the Octorara School System. He is survived by his wife, Arlien.

**Howard F. D. Moser, 1937**

Died September 21, 1973. He had practiced in Prospect Park, Pennsylvania for thirty-one years, specializing in obstetrics and gynecology, tuberculosis and diabetes. He was a member of the medical staff of Taylor Hospital in Ridley Park. Dr. Moser is survived by his wife, Jane.

**Henry J. Whitaker, 1937**

Died December 5, 1973. Dr. Whitaker had maintained a general practice in Ormond Beach, Florida.

**John J. Graff, 1942**

Died December 27, 1973. Dr. Graff, an anesthesiologist, had maintained a private practice and had been Chief of Anesthesiology at St. Francis Hospital in Wilmington until seven years ago. He gave up his practice at that time to devote himself entirely to the crippled and brain-damaged as an administrator with a regional office of HEW. He helped found the Delaware Chapter of United Cerebral Palsy and was its first President. He served as a Fellow of the American Congress of Rehabilitation and the American Academy of Cerebral Palsy and was a member of the faculty of Einstein Medical College in New York. He is survived by his wife, Elizabeth, and five children.

**William B. Holden, 1945**

Died September 2, 1973 at the age of fifty-two. Dr. Holden had been associated with Oak Ridge Hospital in Oak Ridge, Tennessee and maintained a general practice.

**Joseph Mazmanian, 1946**

Died October 4, 1973 at the age of fifty-three. Dr. Mazmanian had practiced general surgery in Stoneham, Massachusetts. He is survived by his wife.

**Virgil W. Samms, Jr., 1950**

Died October 17, 1973. The Eugene, Oregon general practitioner is survived by his wife, Emily.

**Barry C. Gross, 1969**

Died January 10, 1974 in Miami, Florida of a malignant melanoma. A graduate of Dartmouth College, Dr. Gross was a member of Nu Sigma Nu while at Jefferson. He is survived by his wife, Sarah, and two young daughters. Dr. Gross was a neurology resident and worked until shortly before his death.

Members of his class are establishing the Barry Gross Scholarship Fund. Information will be forwarded to classmates shortly.



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**ALL DIVISIONS**  
**SESQUICENTENNIAL FUND DRIVE**  
**TOTAL REPORT AS OF MARCH 29, 1974**

	<u>Goal</u>	<u>Total Reported</u>	<u>% of Goal</u>
Jefferson Family			
Trustees .....	\$ 1,500,000	\$1,225,538	81.7%
Women's Board .....	100,000	70,169	70.1%
Senior Officers .....	40,000	50,000	125.0%
Faculty & Staff .....	800,000	423,219	52.9%
Non-Faculty Employees .....	300,000	211,250	70.4%
Sub-Total .....	\$ 2,740,000	\$1,980,176	72.3%
Foundations .....	5,000,000	991,400	19.8%
Primary Gifts .....	3,000,000	1,733,052	57.8%
Special Gifts .....	1,000,000	20,500	2.1%
Supporting Gifts .....	300,000	3,085	1.0%
Pharmaceutical Gifts .....	400,000	225,000	56.3%
Alumni .....	4,000,000	1,147,639	28.7%
Alumnae .....	100,000	26,931	26.9%
TOTAL .....	\$16,540,000	\$6,127,783	37.0%





## ALUMNI CALENDAR

### April 30

Reception in conjunction with the meetings of the American College of Obstetricians and Gynecologists, the Las Vegas Hilton, Las Vegas

### May 8

Class of 1974 Portrait Presentation, McClellan Hall

### May 8

Reception in conjunction with the meetings of the American Psychiatric Association, the Detroit Hilton, Detroit

### May 11

The Black and Blue Ball, Jefferson Alumni Hall

### May 12

Reception in conjunction with the meetings of the Medical Society of New Jersey, Haddon Hall

### May 22

Reception in conjunction with the meetings of the American Urological Association, the Chase Park Plaza Hotel, St. Louis

### May 28-June 7

Faculty Wives Club Art Show

### June 5

Reunion Clinics  
Dean's Luncheon  
Class Reunion Parties

### June 6

Alumni Banquet  
Bellevue Stratford Hotel

### June 7

Commencement  
Academy of Music